2006 Federal Annual Report
Children's Health Insurance Program

California

Arnold Schwarzenegger, Governor
STATE OF CALIFORNIA
January 2007

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **California**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): Healthy Families/ Medi-Cal for Children

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
X Combination of the above

Reporting Period: ***Federal Fiscal Year 2006*** *Note: Federal Fiscal Year 2006 starts 10/1/05 and ends 9/30/06.*

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Submission Date: _____

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your State, e.g., if you have two types of separate child health programs within your State with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	SCHIP Medicaid Expansion Program					**Separate Child Health Program**				
Eligibility						**From**	200	% of FPL **conception to birth** to	300	% of FPL
	From	0	% of FPL for **infants** to	200	% of FPL	**From**	200	% of FPL for **infants** to	250	% of FPL
	From	0	% of FPL for children ages **1 through 5** to	133	% of FPL	**From**	133	% of FPL for 1 **through 5** to	250	% of FPL
	From	0	% of FPL for children ages **6 through 16** to	100	% of FPL	**From**	100	% of FPL for children ages **6 through 16** to	250	% of FPL
	From	0	% of FPL for children ages **17 and 18** to	100	% of FPL	**From**	100	% of FPL for children ages **17 and 18** to	250	% of FPL
						From	200	% of FPL forAIM-linked infants through 2	300	% of FPL
						From	250	% of FPL for infants through 18 for County/SCHIP	300	% of FPL

Is presumptive eligibility provided for children?	☐	No	☐	No
	☒	Yes, for whom and how long? Beginning 7/1/03, children under 200% receiving services from a CHDP provider will be enrolled in no-cost Medicaid via the CHDP Gateway for two months. In addition, children (ages 0-1 under 200% of the FPL, ages 1-5 under 133% of the FPL, and ages 6-18 under 100% of the FPL) who are screened to the no-cost Medi-Cal program (California's Medicaid Program) are granted presumptive eligibility into Medicaid until final eligibility determinations are made.	☒	Yes, for whom and how long? Children under 200% of the FPL receiving services from a CHDP provider will be enrolled in SCHIP via the CHDP Gateway for two months. In addition, children who are screened to the no-cost Medi-Cal Program are granted presumptive eligibility into Medicaid until final eligibility determinations are made by Medi-Cal.
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☒	No
	☒	Yes, for whom and how long? Yes, for children up to 3 months.	☐	Yes, for whom and how long? **[1000]**
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☒	No
		☐	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No	☐	No
	☒	Yes – please check all that apply	☒	Yes – please check all that apply
	☒	Signature page must be printed and mailed in	☒	Signature page must be printed and mailed in
	☒	Family documentation must be mailed (i.e., income documentation)	☒	Family documentation must be mailed (i.e., income documentation)
	☒	Electronic signature is required	☒	Electronic signature is required
			☐	No Signature is required
	☐	N/A	☐	N/A

Does your program require a face-to-face interview during initial application	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	3 months if the child has employer sponsored insurance.
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☒	Yes	☒	Yes
	Specify number of months	12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	Death of the child, no longer a California resident, or the applicant requests to disenroll the child from the program.		Turning age 19, non-payment of premiums, death of the child, no longer a California resident, or the applicant requests to disenroll the child from the program.	
	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☒	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	$0
	Premium amount		Premium amount	$4 to $15 per month per child with a maximum of $45/month for a family.
	Yearly cap		Yearly cap	$250
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
	[500]		$4 to $15 per month per child with a maximum of $45 per month for a family. Applicant may pay three months in advance and receive the fourth month free. If the applicant uses Electronic Funds Transfer, he/she receives a 25% discount. The $250 yearly cap only applies to health benefit co-payments for all subscribers who reside in one household. In the event the $250 yearly co-payment cap is met, the applicant is still required to make monthly premium payments.	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☒	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☒	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	[500]		**[500]**	
	☐	N/A	☐	N/A

Does your program require income disregards?	☐	No	☐	No
	☒	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
	For infants under one year of age with income between 185% and 200% of the FPL.		Income greater than 200% through 300% of the FPL.	
	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☒	No	☐	No
	☐	Yes, we send out form to family with their information pre-completed and	☒	Yes, we send out form to family with their information pre-completed and
		☐ We send out form to family with their information pre-completed and ask for confirmation		☒ We send out form to family with their information pre-completed and ask for confirmation
		☐ We send out form but do not require a response unless income or other circumstances have changed		☐ We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Comments on Responses in Table:

2. Is there an assets test for children in your Medicaid program? ☐ Yes ☒ No ☐ N/A
3. Is it different from the assets test in your separate child health program? ☐ Yes ☐ No ☒ N/A
4. Are there income disregards for your Medicaid program? ☒ Yes ☐ No ☐ N/A
5. Are they different from the income disregards in your separate child health program? ☐ Yes ☒ No ☐ N/A
6. Is a joint application used for your Medicaid and separate child health program? ☒ Yes ☐ No ☐ N/A

Enter any Narrative text below.

Currently, applicants may apply for the SCHIP and Medicaid programs on-line through the assistance of a Certified Application Assistant (CAA) or County Eligibility Worker (EW). Only CAAs and EWs have access to the on-line electronic application process. The on-line application process for public use is underdevelopment and will be available in 2008.

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7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application	☐	☒	☐	☐	☒	☐
c) Application documentation requirements	☐	☒	☐	☐	☒	☐
d) Benefit structure	☐	☒	☐	☐	☒	☐
e) Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☐	☒	☐
f) Crowd out policies	☐	☒	☐	☐	☒	☐
g) Delivery system	☐	☒	☐	☐	☒	☐
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☒	☐	☐	☒	☐
i) Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j) Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
k) Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
l) Eligibility redetermination process	☐	☒	☐	☐	☒	☐
m) Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
n) Family coverage	☐	☒	☐	☐	☒	☐
o) Outreach (e.g., decrease funds, target outreach)	☒	☐	☐	☒	☐	☐
p) Premium assistance	☐	☒	☐	☐	☒	☐
q) Prenatal Eligibility expansion	☒	☐	☐	☒	☐	☐
r) Waiver populations (funded under title XXI)						
Parents	☐	☒	☐	☐	☒	☐
Pregnant women	☐	☒	☐	☐	☒	☐
Childless adults	☐	☒	☐	☐	☒	☐

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐		☐	☒	☐
t) Other – please specify							
a. **[50]**	☐	☐	☐		☐	☐	☐
b. **[50]**	☐	☐	☐		☐	☐	☐
c. **[50]**	☐	☐	☐		☐	☐	☐

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Application documentation requirements	
d) Benefit structure	
e) Cost sharing (including amounts, populations, & collection process)	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting list or open enrollment period)	
i) Eligibility levels / target population	
j) Assets test in Medicaid and/or SCHIP	
k) Income disregards in Medicaid and/or SCHIP	

l) Eligibility redetermination process	
m) Enrollment process for health plan selection	
n) Family coverage	
o) Outreach	Effective July 1, 2006, the Enrollment Entity/Certified Application Assistant (EE/CAA) reimbursement process increased the amount for on-line applications submitted. For each successful on-line application where a child(ren) is enrolled (in SCHIP and for each application forwarded to the Medi-Cal program where a child is granted presumptive Medicaid eligibility), the amount increased from $50 to $60. In addition, for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP, the EE receives $50 instead of $25. During the last quarter of this reporting period, outreach funding was recently restored to promote public awareness about the SCHIP and Medicaid programs. The $22 million funding allocation will occur on a county level to those counties where the highest number of eligible (but not enrolled) children reside and to counties that have the highest number of SCHIP and Medicaid enrollment in order to promote program retention. The county allocations will be built on existing local structures, experience and knowledge gained by counties. County outreach will utilize a wide variety of community-based organizations that perform targeted outreach and enrollment activities to reach large number of children. Targeted, grassroots outreach activities require the counties to provide innovative and culturally appropriate outreach and enrollment approaches.
p) Premium assistance	
q) Prenatal Eligibility Expansion	On March 28, 2006, CMS approved the pre-natal SPA, where the Medi-Cal for Pregnant Women and Access for Infants & Mothers (AIM) programs will be drawing down federal funds for pregnant women who are enrolled in the programs. Matching federal funds for the Medi-Cal program will occur, so long as the pregnant women are not eligible for prenatal services through the Medi-Cal program. Those infants born to AIM enrolled mothers are automatically eligible for the SCHIP program.

r) Waiver populations (funded under title XXI)

Parents	
Pregnant women	
Childless adults	

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
t) Other – please specify	
a. **[50]**	
b. **[50]**	
c. **[50]**	

Enter any Narrative text below.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three subsections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data is available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures:

- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column report data from the previous two years' annual reports (FFY 2004 and FFY 2005). If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2006). Additional instructions for completing each row of the table are provided below.

If Data Not Reported, Please Explain Why:
If you cannot provide a specific measure, please check the box that applies to your State for each performance measure as follows:

- Population not covered: Check this box if your program does not cover the population included in the measure.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is less than 30. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your State cannot report the measure.

Status of Data Reported:
Please indicate the status of the data you are reporting, as follows:

- Provisional: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.
- Final: Check this box if the data you are reporting is considered final for FFY 2006.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data – administrative data (claims), hybrid data (claims and medical records), survey data, or other source. If another data source was used, please explain the source.

Definition of Population Included in the Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined. Also provide a definition of the numerator (such as the number of visits required for inclusion).

Note: You do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators, denominators, and rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

Note: SARTS will calculate the rate as a percentage if you enter the numerator and denominator. Otherwise, if you only have the rate, enter it in the rate box.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On

the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

MEASURE: Well Child Visits in the First 15 Months of Life

FFY 2004	FFY 2005	FFY 2
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☒ Data not available. *Explain* The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Data is currently being collected and should be reported in the 2007 report ☐ Small sample size (less than 30).- ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☒ Data not available. *Explain*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Data is currently being collected and should be reported in the 2007 report ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please E** ☐ Population not covered. ☒ Data not available. *Explain* Insurance Board's contract with not require the plans to collect first requested by CMS. Data is should be reported report ☐ Small sample size (less than *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a pı *Specify year of annual report in* *reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of H* ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Inclu** Definition of denominator: ☐ Denominator includes SCHI ☐ Denominator includes SCHI Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**

MEASURE: Well Child Visits in the First 15 Months of Life (continued)

FFY 2004	FFY 2005	FFY 2
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: Denominator: Rate: 4 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 5 visits Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 6+ visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: Denominator: Rate: 4 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 5 visits Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 6+ visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI* Percent with specified number o 0 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measuren** *(If reporting with another metho* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress: We will report our first year of data in 2007 to be used as a benchmark for future year comparison and improvements we will use this d

Annual Performance Objective for FFY 2007: 2007 will be our first year of data to be used as a benchmark for future year comparison and improvem benchmarking

Annual Performance Objective for FFY 2008: Monitor data; Work with plans to improve scores if they do not meet Benchmarks. Improve sco Improvement Project. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to impro

Annual Performance Objective for FFY 2009: Monitor data; Work with plans to improve scores if they do not meet Benchmarks. Improve sco Improvement Project. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to impro

Explain how these objectives were set:

Other Comments on Measure:

MEASURE: Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life

FFY 2004	FFY 2005	FFY 2
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☒ Data not available. *Explain*: Data will be available in 2005 ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please E** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: HEDIS 2003 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: HEDIS 2004 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of H* ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☒ Other. *Specify*: Participati (HFP) health plans.
Definition of Population Included in the Measure: Plans provide a random sample of summary data of HFP members who were three, four, five, or six years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Plans provide a random sample of summary data of HFP members who were three, four, five, or six years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Incl** provide a random sample of su who were three, four, five, (measurement year who were plan during the measurement y more well-child visit(s) with a the measurement year. MRMI compares the results with those Definition of denominator: ☒ Denominator includes SCHI ☐ Denominator includes SCHI Definition of numerator:
Year of Data: January – December 2003	**Year of Data:** January – December 2004	**Year of Data:** January – Decem

FFY 2004	FFY 2005	FFY 2
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 10,711 Denominator: 16,980 Rate: 63% Additional notes on measure: The numerator and denominator are based upon a sample of children as required by the NCQA for this HEDIS measure. The numerator and denominator are not reflective of the entire HFP population.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 11,274 Denominator: 17,291 Rate: 65% Additional notes on measure: The numerator and denominator are based upon a sample of children as required by the NCQA for this HEDIS measure. The numerator and denominator are not reflective of the entire HFP population.	**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI* Percent with 1+ visits Numerator: 15,643 Denominator: 24,121 Rate: 65% Additional notes on meas denominator are based upon a s by the NCQA for this HEDIS denominator are not reflective

FFY 2004	FFY 2005	FFY 2
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Additional notes on measure:	**Other Performance Measuren** *(If reporting with another metho* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress: For 2006: based upon the random sample submitted by the plans, it can be imputed that 65% of all applicable HFP enrollees measurement year.

Annual Performance Objective for FFY 2007: Working with plans to improve scores via Quality Performance Improvement Project. Participating health share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2008: Working with plans to improve scores via Quality Performance Improvement Project. Participating health share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2009: Working with plans to improve scores via Quality Performance Improvement Project. Participating health share best practices and lower scoring plans submit a corrective action plan to improve these scores

Explain how these objectives were set: Methodology to be provided as an attachment

Other Comments on Measure:

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2004	FFY 2005	I
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☒ Data not available. *Explain*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in 2006-2007 will be required to report this measurement ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: .	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☒ Data not available. *Explain*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in 2006-2007 will be required to report this measurement ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: .2006-2007	**If Data Not Reported, Pl** ☐ Population not covered ☐ Data not available. *Exp* ☐ Small sample size (less *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported i *Specify year of annual rep* *reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specificati** ☒HEDIS. *Specify versio* ☐HEDIS-like. *Specify ve* *Explain how HEDIS was n* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims ☐ Hybrid (claims and me ☐ Survey data. ☒ Other. *Specify*: Partic (HFP) health plans.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population** Definition of denominator: ☒ Denominator includes S ☐ Denominator includes S Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:** January – D

FFY 2004	FFY 2005	I
HEDIS Performance Measurement Data: **(If reporting with HEDIS/HEDIS-like methodology)** **Percent receiving appropriate medications** **5-9 years** **Numerator:** **Denominator:** **Rate:** **10-17 years** **Numerator:** **Denominator:** **Rate:** **Combined rate (5-17 years)** **Numerator:** **Denominator:** **Rate:** **Additional notes on measure:**	**HEDIS Performance Measurement Data:** **(If reporting with HEDIS/HEDIS-like methodology)** **Percent receiving appropriate medications** **5-9 years** **Numerator:** **Denominator:** **Rate:** **10-17 years** **Numerator:** **Denominator:** **Rate:** **Combined rate (5-17 years)** **Numerator:** **Denominator:** **Rate:** **Additional notes on measure:**	**HEDIS Performance M** **(If reporting with HEI** **Percent receiving appı** **5-9 years** **Numerator:** 2,182 **Denominator:** 2,392 **Rate:** 91% **10-17 years** **Numerator:** 2,399 **Denominator:** 2,711 **Rate:** 88% **18 years** **Numerator:** 147 **Denominator:** 181 **Rate:** 81% **Combined rate (5-18 y** **Numerator:** 4,728 **Denominator:** 5,284 **Rate:** 89% **Additional notes on m**
Other Performance Measurement Data: **(If reporting with another methodology)** **Numerator:** **Denominator:** **Rate:** **Additional notes on measure:**	**Other Performance Measurement Data:** **(If reporting with another methodology)** **Numerator:** **Denominator:** **Rate:** **Additional notes on measure:**	**Other Performance M** **(If reporting with anot** **Numerator:** **Denominator:** **Rate:** **Additional notes on m**

Explanation of Progress:

2006: This is our first year of data to be used as a benchmark for future year comparison and improvements. We will use this data for benchmarking

Annual Performance Objective for FFY 2007: Working with plans to improve scores via Quality Performance Improvement Project. Participating p share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2008: Working with plans to improve scores via Quality Performance Improvement Project. Participating l share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2009: Working with plans to improve scores via Quality Performance Improvement Project. Participating l share best practices and lower scoring plans submit a corrective action plan to improve these scores

Explain how these objectives were set:

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FFY 2004	FFY 2005	I
Other Comments on Measure:		

MEASURE: Children's Access to Primary Care Practitioners

FFY 2004	FFY 2005	I
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**If Data Not Reported, Pl** ☐ Population not covered ☐ Data not available. *Ex* ☐ Small sample size (less *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported i *Specify year of annual rep* *reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: HEDIS 2003 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: HEDIS 2004 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specificati** ☒HEDIS. *Specify versio* ☐HEDIS-like. *Specify ve* *Explain how HEDIS was n* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims ☐ Hybrid (claims and me ☐ Survey data. ☒ Other. *Specify*: Particip (HFP) health plans.

Definition of Population Included in the Measure: Plans identify the continuously enrolled children ages 12 months through 6 years who had a visit with a primary care physician during the measurement year and the continuously enrolled children ages 7 through 18 years who had a visit with a primary care physician during the measurement year or the year preceding the measurement year. Definition of denominator: Total number of children meeting population definition. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Number of children meeting population definition who had a visit.	**Definition of Population Included in the Measure:** Plans identify the continuously enrolled children ages 12 months through 6 years who had a visit with a primary care physician during the measurement year and the continuously enrolled children ages 7 through 18 years who had a visit with a primary care physician during the measurement year or the year preceding the measurement year. Definition of denominator: Total number of children meeting population definition. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Number of children meeting population definition who had a visit.	**Definition of Population** identify the continuously through 6 years who had a during the measurement y children ages 7 through primary care physician du year preceding the measur Definition of denominator population definition. ☒ Denominator includes S ☐ Denominator includes S Definition of numerator population definition who
Year of Data: January – December 2003	**Year of Data:** January – December 2004	**Year of Data:** January – I
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit	**HEDIS Performance Me** *(If reporting with HEDIS/H* Percent with a PCP visit
12-24 months Numerator: 6,827 Denominator: 7,306 Rate: 93% 25 months-6 years Numerator: 78,001 Denominator: 93,509 Rate: 83% 7-11 years Numerator: 75,948 Denominator: 92,391 Rate: 82% 12-19 years: Not Collected Numerator: Denominator: Rate: Additional notes on measure:	12-24 months Numerator: 8,129 Denominator: 8,904 Rate: 91% 25 months-6 years Numerator: 92,350 Denominator: 113,441 Rate: 81% 7-11 years Numerator: 79,199 Denominator: 97,579 Rate: 81% 12-19 years: Not Collected Numerator: Denominator: Rate: Additional notes on measure:	12-24 months Numerator: 7,868 Denominator: 8,476 Rate: 93% 25 months-6 years Numerator: 102,489 Denominator: 117,196 Rate: 87% Additional notes on measu

FFY 2004	FFY 2005	I
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Mea** *(If reporting with another* Numerator: Denominator: Rate: Additional notes on measu

Explanation of Progress: For 2006: Based upon the data submitted by the plans, it can be imputed that 87% of all applicable HFP enrollees had access measurement year.

Annual Performance Objective for FFY 2007: Working with plans to improve scores via Quality Performance Improvement Project. Participating share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2008: Working with plans to improve scores via Quality Performance Improvement Project. Participating share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2009: Working with plans to improve scores via Quality Performance Improvement Project. Participating share best practices and lower scoring plans submit a corrective action plan to improve these scores

Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2005	FFY 2006	Percent change FFY 2005-2006
SCHIP Medicaid Expansion Program	**181,017**	**214,216**	**%18**
Separate Child Health Program	**1,042,458**	**1,177,189**	**%13**

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

   SCHIP Medicaid Expansion Program: The One Month Bridge caseload across the state continues to grow. Los Angeles began reporting One Month Bridge caseload in March 2005 and continues to report increasing numbers of 7X eligibles which accounts fro about ¼ of the growth from 2005-2006.

   Separate Child Health Program: Expansion of outreach and increased retention efforts have contributed to the increase enrollment in the HFP program.

2. The table below shows trends in three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS) along with the percent change between 1996-1998 and 2003-2005. Significant changes are denoted with an asterisk (*). If your State uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2006 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number (In Thousands)	Std. Error	Rate	Std. Error
1996-1998				
1998-2000				
2000-2002				
2003-2005				
Percent change 1996-1998 vs. 2003-2005				

   A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children.

[7500]

B. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates. **[7500]**

3. Please indicate by checking the box below whether your State has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

X Yes (please report your data in the table below)

No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	California Health Interview Survey (CHIS)
Reporting period (2 or more points in time)	2001, 2003 and 2005
Methodology	The baseline for 2001 and 2003 was calculated by using Medi-Cal and HFP enrollment data and the 2000 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found in *The State of Health Insurance in California: Recent Trends, Future Prospects* and at the UCLA Centers website: www.healthpolicy.ucla.edu. The methodology used for estimating the baseline did not change. 2005: UCLA has issued a fact sheet on coverage, but the full report which explains the methodology will not be issued until the end of January 2007.
Population (Please include ages and income levels)	CHIS is a general population survey that examines health insurance coverage, as well as numerous other issues. It surveys households through random selection and does so in five languages.
Sample sizes	2001 Survey: 55,000 households with over samples of Asian Pacific Islanders and American Indian/Alaska Natives. This sample included 5,000-6,000 adolescents and 14,000 children by proxy. 2003: Survey: 40,000 households with 4,000 adolescents and 9,000 children by proxy. Over samples were done of Koreans and Vietnamese. 2005: The full report which details sample sizes will not be issued until the end of January 2007.

Number and/or rate for two or more points in time	Coverage of children enrolled under Medi-Cal and HFP continues to increase: 2001 - 24.2%; 2003 - 29.2%; and 2005: 30.9%. The percentage of uninsured children decreased from 2001 (14.8%) to 2003 (11.3%) to 2005 (10.7%). The number of children with employer sponsored coverage decreased from 2001 (55.1%) to 2003 (50.8%) to 2005 (50.3%). NOTE: The 2005 data comes from two documents developed by the University of California, Los Angeles Center for Health Policy Research that provide a preview of the upcoming 2005-2007 CHIS report. The two documents are: "More than Half of California's Uninsured Children Eligible for Public Programs But not Enrolled" and "One in Five Californians Were Uninsured in 2005 Despite Modest Gains in Coverage" The full CHIS report will be issued at the end of January 2007.
Statistical significance of results	• Increases in the number of children enrolled in HFP or Medi-Cal are statistically significant both for 2001-2003 and 2003-2005. • Decreases in the percentage of uninsured children were statistically significant between 2001-2003. • Decreases in the percentage of employer sponsored coverage were statistically significant between 2001 and 2003.

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A. Please explain why your State chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.
California uses a state survey, the California Health Interview Survey (CHIS) because its sample size is higher than CPS, which allows for better estimates of subgroups. CHIS also asks more detailed questions about eligibility for public programs (Medi-Cal /HFP). However, a 2004 report issued by the California Healthcare Foundation (CHCF) *Memorandum on Data Guide: Analysis Results for Understanding Survey Estimates of California's Uninsured and Medi-Cal Populations* (Feldman, Schur, Berk and Kintala) suggest adjusting CHIS estimates of uninsured children by a factor of 1.6 when absolute size matters. Figures detailed above are not adjusted.

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B. What is your State's assessment of the reliability of the estimate? Please provide standard errors, confidence intervals, and/or p-values if available.
As the CHCF report indicates, no survey tool is perfect. Given its larger sample size, and greater precision asking eligibility questions, California considers the estimate reliable. However, for cross state comparison, either CPS should be used or an adjusted CHIS estimate. As noted above, the report suggests adjusting CHIS estimates of uninsured children by a factor of 1.6.

C. What are the limitations of the data or estimation methodology?
CHIS is a telephone survey, not an in-person survey which could produce some bias. This issue will be explored in the 2007 CHIS.
Also, state surveys generally tend to produce lower estimates of the uninsured. As noted above, the CHCF study suggests adjusting estimates of uninsured children by a factor of 1.6.

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

While the State does not actively collect data estimating the impact of outreach and enrollment simplification, the State believes outreach and enrollment simplification played a major role in SCHIP's and Medicaid's continuing increase in enrollment. The State funding for statewide media outreach campaigns stopped on July 1, 2003. However, the State continued to work closely with the David and Lucille Packard Foundation and Public Health Institute to sponsor the Connecting Kids to Healthcare Through Schools Project. This Project focuses on statewide school-based outreach and enrollment for the SCHIP, Medicaid and Children's Expansion Programs (e.g. Healthy Kids Programs). As a result of the school based outreach, during this reporting period, over 1,082,000 outreach materials were distributed to schools. The schools disseminated the materials to parents with their Back-to-School packets, at Back-to-School Nights, Parent/Teacher Conferences, and with school lunch menus. The dissemination of outreach materials resulted in over 24,790 parents requesting applications to be mailed to them. Many of the outreach materials were customized with local contact information, so the number of applications requested is understated for this outreach goal.

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In addition, outreach still exists at the local levels for a wide variety of Children's Expansion Programs. For many of these programs outreach and enrollment is privately funded through Foundations and Local First 5 Commissions. In those counties with Children's Expansion Programs, there have been positive impacts on both the Medi-Cal for Children and SCHIP Programs in California.

During the last quarter of this reporting period, outreach funding was restored to promote public awareness of the SCHIP and Medicaid programs. During the next reporting period, $22 million will be allocated and distributed on a county level to those counties where the highest number of eligible (but not enrolled) children reside and to counties that have the highest number of SCHIP and Medicaid enrollment in order to promote retention. The county allocations will build on the existing local structures, experience and knowledge gained by counties in their efforts to increase enrollment of uninsured children and program retention. County outreach utilizes a wide variety of community-based organizations that perform targeted outreach and enrollment activities to reach large number of children. Targeted, grassroots outreach activities require the counties to provide innovative and culturally appropriate outreach and enrollment approaches. While outreach funding was allocated during this reporting period, funding has not been distributed to the counties. Next year's report will provide more detailed information on the overall impact of outreach funding.

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Effective July 1, 2005, the EE/CAA reimbursement process was restored for each successful application where a child(ren) is enrolled. Beginning July 1, 2006, the EE/CAA reimbursement process increased the amount for on-line applications submitted. For each successful on-line application where a child(ren) is enrolled (in SCHIP and for each application forwarded to the Medi-Cal program where a child is granted presumptive Medicaid eligibility), the amount increased from $50 to $60. In addition, for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIPSHIP, the EE receives $50 instead of $25. As of September 2006, 17,015 CAAs assisted families in applying for the SCHIP and Medicaid programs. This is over a 1,400% increase in CAA participation compared to the previous reporting period. The number of applications assisted by CAAs increased from approximately 17.2% to 26.54%. The number of complete applications received significantly increased from approximately 19% to 47.10%. During the initial application process, 61.85% eligible children who were enrolled in SCHIP obtained assistance from CAAs. During the Annual Eligibility Review process, 12.67% of children continued to be eligible for SCHIP through the assistance of CAAs.

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SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. The format of this section has been revised for FFY 2006 to provide your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- SCHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, please enter the data you reported for each objective in the previous two years' annual reports (FFY 2004 and FFY 2005). In the third column, please report the most recent data available at the time you are submitting the annual report.

Note that the term *performance measure* is used differently in Section IIA versus IIC. In Section IIA, the term refers to the four core child health performance measures. In this section, the term is used more broadly, to refer to any data your State provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are State-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported in Sections IIA or IIB. The intent of this section is to capture goals and measures that your State did not report elsewhere in Section II.

Additional instructions for completing each row of the table are provided below.

Goal:
For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective.

Type of Goal:
For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.
- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.
- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:
Please indicate the status of the data you are reporting for each goal, as follows:

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.
- Final: Check this box if the data you are reporting is considered final for FFY 2006.
- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
This section is included for only two of the objectives — objectives related to increasing access to care, and objectives related to use of preventative care — because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and SCHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source. For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims), hybrid data (claims and medical records), survey data (specify the survey used), or other source. In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Also provide a definition of the numerator (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

For measures related to increasing access to care and use of preventative care, please also check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Performance Measurement Data:
Describe what is being measured: Please provide a brief explanation of the information you intend to capture through the performance measure.

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for

each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3)

FFY 2004	FFY 2005	FFY 2
Goal #1 (Describe) Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	**Goal #1 (Describe)** Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	**Goal #1 (Describe)** Increase eligible children who are program.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. X Final. Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. X Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. X Final. ☐ Same data as reported in a p *Specify year of annual report in reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: California Department of Health Services	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: California Department of Health Services	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: :California D
Definition of Population Included in the Measure: Eligible children in Medicaid in FFY 2003-2004 Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Eligible children in Medicaid in FFY 2004-2005 Definition of denominator: Definition of numerator:	**Definition of Population Inclu** Eligible children in Medicaid in Definition of denominator: Definition of numerator:
Year of Data: : June 2003– June 2004	**Year of Data:** June 2004 – June 2005	**Year of Data: :** June 2005 – Ju
Performance Measurement Data: Describe what is being measured: Analyze changes in number of eligible children in Medicaid in FFY 2003 and 2004. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Analyze changes in number of eligible children in Medicaid in FFY 2004 and 2005. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement D** Describe what is being mea number of eligible children in 2006. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2
Explanation of Progress: For 2005: There has been an overall increase of 31,525 in the total number of children in Medi-Cal between June 2004 and June 2(program, the number of children enrolled increased by 22,592 from 3,178,470 to 3,201,062. In the Medi-Cal Expansion program, the number of children incre 88,508. In California's One-Month Bridge Program, the number of children enrolled increased by 1,777 from 2,545 to 4,322. Increases in the One Month Bridge implementing new eligibility determination systems or upgrading current systems. This includes much improved reporting for California's largest county, Los An For 2006: In the Medi-Cal Expansion program, the number of children increased by 17,458 from 41,664 to 59,122 children. The One Month Bridge caseload grow. Los Angeles which began reporting One Month Bridge in March 2005 continues to report increasing numbers of 7X eligibles which accounts for about 1 2006. " **Annual Performance Objective for FFY 2007:** Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2008:** Achieve improvements in enrolling eligible children **Annual Performance Objective for FFY 2009:** Achieve improvements in enrolling eligible children *Explain how these objectives were set:*		
Other Comments on Measure: For 2005:The increase in the number of children in the regular Medi-Cal program is due to continuing minor growth in cove (Section 1931(b) of the Social Security Act) and efforts to facilitate the Medi-Cal application process for children through the Child Health and Disability Gateway, Express Lane application through the schools for children eligible for the National School Lunch Program, and accelerated enrollment for children thro (SPE). The increased enrollment in the Medi-Cal Expansion program appears to be attributable to the growth in applications for children primarily through property information is not required for these applications. Seventy two percent of applications through the SPE requested coverage for children only. In order One-Month Bridge Program, the Administration has proposed the implementation of Healthy Families Bridge performance standards for counties, starting in children potentially eligible are referred to Healthy Families through the One-Month Bridge Program.		

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Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (continued)

FFY 2004	FFY 2005	FFY 2
Goal #2 (Describe) Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	**Goal #2 (Describe)** Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal	**Goal #2 (Describe))** Reduc children in target income fami above no-cost Medi-Cal
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2003	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☒ Provisional. ☐ Final. ☐ Same data as reported in a pı *Specify year of annual report in reported:* 2005
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other Source. *Specify*: "The State of Health Insurance in California: Findings from the 2001 and 2003 California Health Interview Survey" (Brown, et.al, UCLA 2004)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: X Other Source. *Specify*: "The State of Health Insurance in California: Findings from the 2001 and 2003 California Health Interview Survey" (Brown, et.al, UCLA 2004)	**Data Source:** ☐ Eligibility/Enrollment data ☒ Survey data. *Specify*: Prev report to be issued at the end of ☐ Other Source. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Inclu** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Analyze changes in number of eligible uninsured children between 2001 and 2003 who were eligible for Medi-Cal or Healthy Families Program. Numerator: 224000 (# eligible for but not enrolled in HFP in 2001) Denominator: 301000 (# eligible for but not enrolled in HFP in 2003) Rate: 25%; estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal. Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Analyze changes in number of eligible uninsured children between 2001 and 2003 who were eligible for Medi-Cal or Healthy Families Program. Numerator: 224000 (# eligible for but not enrolled in HFP in 2001) Denominator: 301000 (# eligible for but not enrolled in HFP in 2003) Rate: 25%; estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal Additional notes on measure:	**Performance Measurement Da** Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure: data. Report on 2005 to be issue

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Describe what is being measured:

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Denominator:

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Rate:

FFY 2004	FFY 2005	FFY 2
Explanation of Progress: **Annual Performance Objective for FFY 2007:** Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2008:** Achieve improvements in enrolling eligible children **Annual Performance Objective for FFY 2009:** Achieve improvements in enrolling eligible children *Explain how these objectives were set:*		
Other Comments on Measure: For 2005: According to the 2003 CHIS, only 9.1% of parents were unaware of HFP, compared to 23.3% who were unawar continue utilizing CHIS to measure changes in the number of uninsured children. Collection of new data for the 2005-2007 CHIS survey began in July 2(December 2005. Data from the 2005 survey should be available beginning in early 2007.		

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Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (continued)

FFY 2004	FFY 2005	FFY 2
Goal #3 (Describe) Reduce the percentage of children using the emergency room as their usual source of primary care.	**Goal #3 (Describe)** Reduce the percentage of children using the emergency room as their usual source of primary care.	**Goal #3 (Describe)** Reduc using the emergency room as t care.
Type of Goal: ☐ New/revised. ☐ Continuing ☒ Discontinued. *Explain*: Program does not currently collect claims/encounter data; therefore, cannot determine if EF utilization is excessive.	**Type of Goal:** ☐ New/revised. ☐ Continuing ☒ Discontinued. *Explain*: Program does not currently collect claims/ encounter data; therefore, cannot determine if EF utilization is excessive.	**Type of Goal:** ☐ New/revised. ☐ Continuing ☒ Discontinued. *Explain*: collect claims/encounter data; t EF utilization is excessive.
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a pr *Specify year of annual report in reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other Source. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other Source. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other Source. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Inclu** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Da** Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to SCHIP Enrollment

FFY 2004	FFY 2005	FFY 2
Goal #1 (Describe) Provide an application and enrollment process which is easy to understand and use.	**Goal #1 (Describe)** Provide an application and enrollment process which is easy to understand and use.	**Goal #1 (Describe)** Provide process which is easy to underst
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Inclu** Definition of denominator: N/A Definition of numerator: N/A
Year of Data: 2003-2004	**Year of Data:** 2004-2005	**Year of Data:** 2005-2006
Performance Measurement Data: Describe what is being measured: Ensuring that written and telephone services are provided in the appropriate languages for the target population. Numerator: N/A Denominator: N/A Rate: N/A Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Ensuring that written and telephone services are provided in the appropriate languages for the target population. Numerator: N/A Denominator: N/A Rate: N/A Additional notes on measure:	**Performance Measurement Da** Describe what is being measur telephone services are provided for the target population. Numerator: N/A Denominator: N/A Rate: N/A Additional notes on measure:

FFY 2004	FFY 2005	FFY 2

Explanation of Progress: Applicants can receive enrollment instructions, applications, and handbooks in 10 languages. These languages include English, Spanish, Vietnamese, Cantonese, Korean, Russian, Hmong and Farsi. In addition, HFP has all correspondence, billing invoices, and other program notification materials available in 5 languages: Englis Vietnamese. The program's administrative vendor maintains 3 toll-free lines to provide pre- and post-enrollment assistance. These lines operate Monday through Friday from 8:0 from 8:00 a.m. to 5:00 p.m. The toll-free HFP information line (800-880-5305) and the Medi-Cal outreach line (888-747-1222) are staffed with enrollment specialists who information, provide enrollment assistance, give families information on the status of their application, and provide support to Enrollment Entities and Certified Application Assistant operators proficient in the 11 designated languages in which campaign materials are published. A special toll free member services number (866-848-9166) is also available to ass and/or changes to their account, and provide members with information about eligibility appeals. The line is staffed with operators proficient in all of the 11 languages.

Annual Performance Objective for FFY 2007: Currently, the existing application is close to a 10th grade reading level. The State has developed a understand and read in order to eliminate any barriers that discourage individuals from applying for the SCHIP and Medicaid programs. Improvements i language, reducing the reading grade level, effectively communicating/presenting important program information, including a document check list to ensur the necessary information needed to ensure that the application is complete, and making the application more visually appealing for the target population.

Another performance objective for FFY 2007 includes streamlining the enrollment process by no longer requiring initial premium payments to be included as the applicants' plan selections. Eligible children will no longer be denied SCHIP coverage in the event the payments and plan selections are not pr process. Instead, an applicant will receive a monthly statement for the child's first full month's coverage. In the event the applicant does not provide his enrollment process, the eligible child will be assigned to the community provider plan and alternately assigned to the dental and vision plans. An estimat year either do not get enrolled or experience delay in enrollment into SCHIP as a result of not providing the premium payments or identifying plan selection

The State is scheduled to implement a SCHIP presumptive eligibility process to replace the Medi-Cal to HFP one-month bridge coverage. Currently, in the in Medi-Cal no longer qualifies for the program, the child remains enrolled in Medi-Cal for one additional month until an SCHIP eligibility determination i replace the Medi-Cal one-month bridge coverage with SCHIP presumptive eligibility until the HFP conducts an eligibility determination. The new pr certification of income during the SCHIP Annual Eligibility Review process, implement county pilot projects for Medi-Cal and establish an electronic gatev Children (WIC) program.

Annual Performance Objective for FFY 2008: California is partnering with two private philanthropic foundations to expand the access of the existing process for general public use. When the on-line application is used, the overall amount of missing information is reduced dramatically because of the ste complete the application. For example, the electronic application provides automated context-based assistance when filling out the application. The ap unless all required information is entered into the electronic form. All information on the forms is automatically captured and electronically transmi Currently, applicants may apply for the SCHIP and Medicaid programs on-line through the assistance of a Certified Application Assistant (CAA) or Cou Only CAAs and EWs have access to the on-line electronic application process.

Annual Performance Objective for FFY 2009: To be determined

Explain how these objectives were set:

Other Comments on Measure:

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Objectives Related to SCHIP Enrollment (continued)

FFY 2004	FFY 2005	FFY 2
Goal #2 (Describe) Ensure the participation of community-based organizations in outreach/education activities.	**Goal #2 (Describe)** Ensure the participation of community-based organizations in outreach/education activities.	**Goal #2 (Describe)** Encourag participation of EEs/CAAs in th processes, enhance EE/CAA inc reimbursement amount, and con and county outreach grants..
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data.	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Enrollment Enrollment Data.
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Inclu** Definition of denominator: N/A Definition of numerator: N/A
Year of Data: 2003-2004	**Year of Data:** 2004-2005	**Year of Data:** 2005-2006
Performance Measurement Data: Describe what is being measured: Ensure that a variety of entities experienced in working with target populations are eligible for an Application Assistance Fee. Numerator: N/A Denominator: N/A Rate: N/A Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Ensure that a variety of entities experienced in working with target populations are eligible for an Application Assistance Fee. Numerator: N/A Denominator: N/A Rate: N/A Additional notes on measure:	**Performance Measurement Da** Describe what is being meas EE/CAAs providing application Numerator: N/A Denominator: N/A Rate: N/A Additional notes on measure:

FFY 2004	FFY 2005	FFY 2

Explanation of Progress: Effective July 1, 2005, the EE/CAA reimbursement process was restored for each successful application where a child(ren) is enrolled. Effective July 1, 2 process increased the amount for on-line applications submitted. For each successful on-line application where a child(ren) is enrolled (in SCHIP and for each application forwarc amount increased from $50 to $60. In addition, for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP, the EE receives $50 instea 17,015 CAAs assisted families in applying for the SCHIP and Medicaid programs. This is over a 1,400% increase in CAA participation compared to the previous reporting per assisted by CAAs increased from approximately 17.2% to 26.54%. The number of complete applications received significantly increased from approximately 19% to 47.10%. Duri 61.85% eligible children who were enrolled in SCHIP obtained assistance from CAAs. During the Annual Eligibility Review (AER) process, 12.67% of children continued to b assistance of CAAs.

Annual Performance Objective for FFY 2007: Although there was significant increase in the number of EEs/CAAs providing assistance to families compared to the prev objective is to increase the number of EE/CAA participation. EEs/CAAs assist families in filling out the applications and SCHIP AER forms, ensuring that all necessary docu the applications to be considered complete. The level of EE/CAA participation typically results in more complete applications and AER forms being received. A complete ap process for eligible children and prevents eligible children from being disenrolled from SCHIP during the AER process. Incomplete applications and AER forms require signi to obtain the missing information and may delay the enrollment or may result in the disenrollment of eligible children.

In addition, during the last quarter of the 2006 reporting period, outreach funding was recently restored to promote public awareness of the SCHIP and Medicaid programs. funding allocation will occur on a county level to those counties with the highest number of eligible (but not enrolled) children reside and to counties that have the highest enrollment in order to promote program retention. The county allocations will build on the existing local structures, experiences and knowledge gained by counties in their uninsured children and program retention. County outreach will utilize a wide variety of community-based organizations that perform targeted outreach and enrollment ac children. Targeted, grassroots outreach activities requires the counties to provide innovative and culturally appropriate outreach and enrollment approaches. The object enrollment of uninsured children will increase and that program retention occurs through the county outreach efforts.

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Annual Performance Objective for FFY 2008: Continue to encourage and increase community-based organizations' and EEs/CAAs' participation in outreach for the Medic

Annual Performance Objective for FFY 2009: Continue to encourage and increase community-based organizations' and EEs/CAAs' participation in outreach for the Medic

Explain how these objectives were set:

Other Comments on Measure:

Objectives Related to Medicaid Enrollment -

FFY 2004	FFY 2005	FFY 2
Goal #1 (Describe)	**Goal #1 (Describe)**	**Goal #1 (Describe)**
Type of Goal: ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Inclu** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement D** Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (continued)

FFY 2004	FFY 2005	FFY 2
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a p *Specify year of annual repor reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Inclu** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement D** Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (continued)

FFY 2004	FFY 2005	FFY 2
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☐ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a p *Specify year of annual repor reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Inclu** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement D** Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure:
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2004	FFY 2005	FFY 2
Goal #1 (Describe) Provide each family with two or more health plan choices for their children.	**Goal #1 (Describe)** Provide each family with two or more health plan choices for their children.	**Goal #1 (Describe)** Provide health plan choices for their chil
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of H* ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor – Electronic Data Systems (EDS)	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor MAXIMUS.	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☒ Other. *Specify*: Enroll Administrative Vendor MAXIM
Definition of Population Included in the Measure: Definition of denominator: Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Inclu** Definition of denominator: ☐ Denominator includes SCHI ☐ Denominator includes SCHI Definition of numerator:
Year of Data: 2004	**Year of Data: 2005**	**Year of Data: 2006**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI* Numerator: Denominator: Rate: Additional notes on measure:

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need) (continued)

Other Performance Measurement Data:	**Other Performance Measurement Data:**	**Other Performance Measuren**
(If reporting with another methodology)	*(If reporting with another methodology)*	*(If reporting with another metho*
Describe what is being measured:	Describe what is being measured:	Describe what is being measure
Numerator:	Numerator:	Numerator:
Denominator:	Denominator:	Denominator:
Rate:	Rate:	Rate:
Additional notes on measure:	Additional notes on measure:	Additional notes on measure:

Explanation of Progress: For 2004: HFP offered a broad range of health plans for program subscribers. A total of 27 health plans participated in the program Over 99.72% of subscribers had a choice of at least two health plans from which to select. The 0.28% of subscribers who had a choice of only one health plan m the state where access to health care services are limited. These subscribers were enrolled in exclusive provider organization plans (EPO) that provide a broad net counties, subscribers had a choice of up to 3 or more health plans. In 4 of these 37 counties, members could choose from up to 7 health plans.

For 2005: A total of 26 health plans participated in the program during the reporting period. Over 99.70% of subscribers had a choice of at least two health pl 0.30% of subscribers who had a choice of only one health plan mostly resided in rural areas of the state where access to health care services are limited. These exclusive provider organization plans (EPO) that provide a broad network of providers. In 39 of 58 counties, subscribers had a choice of up to 3 or more health pl members could choose from up to 8 health plans.

For 2006: A total of 27 health plans participated in the program during the reporting period. Over 99.6% of subscribers have a choice of at least two health pl 0.30% of subscribers who have a choice of only one health plan mostly reside in rural areas of the state where access to health care services are limited. The exclusive provider organization plans (EPO) that provide a broad network of providers. In 40 of 58 counties, subscribers have a choice of up to 3 or more heal members had a choice of at least 7 health plans. In 4 of these 39 counties, members can choose from up to 6 health plans.

Annual Performance Objective for FFY 2007: MRMIB will continue to offer a broad range of options to subscribers across the State.

Annual Performance Objective for FFY 2008: MRMIB will continue to offer a broad range of options to subscribers across the State.

Annual Performance Objective for FFY 2009: MRMIB will continue to offer a broad range of options to subscribers across the State.

Explain how these objectives were set:

Other Comments on Measure:

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Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (continued)

FFY 2004	FFY 2005	FFY 2
Goal #2 (Describe) Ensure broad access in each county to Traditional and Safety Net providers for all Healthy Families Program members.	**Goal #2 (Describe)** Ensure broad access in each county to Traditional and Safety Net providers for all Healthy Families Program Members.	**Goal #2 (Describe)**) Ensur to Traditional and Safety Ne Families Program Members.
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a p *Specify year of annual repor reported:* 2005
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of H* ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☒ Other. *Specify*: Participatir (HFP) health plans.
Definition of Population Included in the Measure: Traditional and Safety Net providers (clinics, CHDP providers and hospitals) in each county, as defined in Section 12693.21 of the Insurance Code. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Traditional and Safety Net providers (clinics, CHDP providers and hospitals) in each county, as defined in Section 12693.21 of the Insurance Code. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population I** Traditional and Safety Net providers and hospitals) in each 12693.21 of the Insurance Code Definition of denominator: ☒ Denominator includes SCHI ☐ Denominator includes SCHI Definition of numerator:
Year of Data: Calendar year 2004	**Year of Data: calendar year 2005**	**Year of Data: calendar year 2**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI* Numerator: Denominator: Rate: Additional notes on measure:

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (continued)

Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: The Traditional and Safety Net (T&SN) Providers in each county by plan. Health plans use a list supplied by MRMIB to report the number of T&SN providers in their network. Health plans with the highest T&SN participation are given a $3 discount on each member's monthly premium. Numerator: Members established with T&SN provider. Denominator: Total HFP membership Rate: 62% Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: The Traditional and Safety Net (T&SN) Providers in each county by plan. Health plans use a list supplied by MRMIB to report the number of T&SN providers in their network. Health plans with the highest T&SN participation are given a $3 discount on each member's monthly premium. Numerator: Members established with T&SN provider Denominator: Total HFP membership Rate: 62% Additional notes on measure:	**Other Performance Measuren** *(If reporting with another metho*

Explanation of Progress: For 2004, 2005 and 2006: HFP participating health plans continue to include T&SN providers in their network and to participate i designated plan allowed to offer the HFP product at a discount. For both 2004 and 2005, 62% of HFP members either selected or were assigned a TSN primary c will not be released until next year. This rate has remained consistent from 2002 through 2005..

Annual Performance Objective for FFY 2007: We will continue to measure levels of TS&N Providers participating in HFP and continue to provide s choosing TS&N providers.

Annual Performance Objective for FFY 2008: We will continue to measure levels of TS&N Providers participating in HFP and continue to provide s choosing TS&N providers.

Annual Performance Objective for FFY 2009: We will continue to measure levels of TS&N Providers participating in HFP and continue to provide s choosing TS&N providers.

Explain how these objectives were set:

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2004	FFY 2005	FFY 2
Goal #1 (Describe) Maintain or improve the percentage of children receiving CCS and mental health (SED) specialized services.	**Goal #1 (Describe)** Maintain or improve the percentage of children receiving CCS and mental health (SED) specialized services	**Goal #1 (Describe)** Maintain children receiving CCS and me services
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: HFP enrollment, CCS, and County mental health data.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: HFP enrollment, CCS, and County mental health data.	**Measurement Specification:** ☐HEDIS. *Specify version of H* ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☒Other. *Explain*: HFP enrollm health data.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS, and County mental health data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS, and County mental health data.	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☒ Other. *Specify*: HFP enrollm health data.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Inclu** Definition of denominator: ☒ Denominator includes SCHI ☐ Denominator includes SCHI Definition of numerator:
Year of Data: July 1 2002-June 30 2003	**Year of Data: July 1 2003-June 30 2004**	**Year of Data: July 1 2004-Jun**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI* Numerator: Denominator: Rate: Additional notes on measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (continued)

Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Number of Children Receiving CCS or SED Services Denominator: Total HFP population Rate: CCS: 2.5%; SED: 0.7% Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Number of Children Receiving CCS or SED Services Denominator: Total HFP population Rate: CCS: 3%; SED: 0.87% Additional notes on measure:	**Other Performance Measuren** *(If reporting with another metho* Describe what is being measure Numerator: Number of Childı Services Denominator: Total HFP popula Rate: CCS: 3%; SED: Da Additional notes on measure:

Explanation of Progress: The percentage of children receiving CCS services has remained constant over the last 2 reporting periods (July 03-June 04; July 0
children receiving SED services has increased slightly over 2 reporting periods (July 02-June 03; July 03-June 04).

Annual Performance Objective for FFY 2007: Assure children needing these services receive them. We will continue to monitor rates of children rece with stakeholders to see if rates improve service levels.

Annual Performance Objective for FFY 2008: : Assure children needing these services receive them. We will continue to monitor rates of children rece with stakeholders to see if rates improve service levels.

Annual Performance Objective for FFY 2009: : Assure children needing these services receive them. We will continue to monitor rates of children rece with stakeholders to see if rates improve service levels.
Explain how these objectives were set:

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (continued)

FFY 2004	FFY 2005	FFY 2
Goal #2 (Describe) Ensure no break in coverage for children who access CCS and SED specialized services	**Goal #2 (Describe)** Ensure no break in coverage for children who access CCS and SED specialized services	**Goal #2 (Describe)** Ensur children who access CCS and S
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a p *Specify year of annual repor reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of H* ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS and County mental health data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS and County mental health data.	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☒ Other. *Specify*: HFP enrollr health data.
Definition of Population Included in the Measure: Definition of denominator: X☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: X☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Inclu** Definition of denominator: X☐ Denominator includes SCI ☐ Denominator includes SCHI Definition of numerator:
Year of Data: 2002	**Year of Data: 2003**	**Year of Data: 2004**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI* Numerator: Denominator: Rate: Additional notes on measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (continued)

Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measuren** *(If reporting with another metho* Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress: For 2005: The State continues to monitor access to services for children with special health care needs as it has since the inceptio coordination of care for HFP subscribers who are eligible for the CCS and county mental health services, the Managed Risk Medical Insurance Board (MRMIB) Understanding (MOU) for use by HFP participating plans and county CCS and mental health programs. The MOU describes a common set of responsibilities fo county CCS and mental health programs. Plans participating in the HFP are required to submit a MOU that has been signed by a plan official, a county CC official. MOU's are required in every county in which the plan serves the HFP. The State holds meetings with health, dental and vision plans and the CCS and c as needed, and follows-up on complaints received from subscribers. The meetings with plans and the programs allow the State, the plans and the county progr have with the MOUs, any arising or foreseeable barriers to access, and ways to eliminate these barriers. Newsletters were developed for county mental health protocols for health plan/county mental health referrals and to provide county mental health departments with updates on the HFP. The California Institute of M with the State developed these newsletters. During the reporting period, brochures were distributed to families to better educate them about the CCS and the count

For 2006: Memorandums of Understanding (MOUs) between participating HFP plans and county CCS and mental health plans and county CCS and menta coordination of care for HFP subscribers. In addition, ongoing meetings and the use of newsletters allow the State, health, dental and vision plans and the coun communication on such topics as barriers to access, referral issues, subscriber complaints, and treatment/payment coverage.

Annual Performance Objective for FFY 2007: Implementation of recommendations from an evaluation of SED/Mental Health Services in Healthy Famil Creation of state-wide forum of health plans and county mental health departments to discuss issues related to referrals, assessment and treatment Redesign of refe Research and Development of standardized assessment tool; Emphasis on early and periodic screening; Increased Communication between counties, plans and pr Continuous communication between State, health, dental and vision plans and the county CCS and MH programs regarding barriers to access, referral issue treatment/payment coverage

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Annual Performance Objective for FFY 2008: Continuous communication between State, health, dental and vision plans and the county programs regard issues, subscriber complaints, and treatment/payment coverage

Annual Performance Objective for FFY 2009: Continuous communication between State, health, dental and vision plans and the county programs regard issues, subscriber complaints, and treatment/payment coverage

Explain how these objectives were set:

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (continued)

FFY 2004	FFY 2005	FFY 2
Goal #3 (Describe) Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	**Goal #3 (Describe)** Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	**Goal #3 (Describe)** Achiev in the number of children that care physician during the year.
Type of Goal: ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. ☒ Continuing ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a pı *Specify year of annual repor reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2003 Measure for Access. ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2004 Measure of Access. ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of H* Access. ☐HEDIS-like. *Specify version* *Explain how HEDIS was modifi* ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data) ☐ Hybrid (claims and medical ☐ Survey data. ☒ Other. *Specify*: Participati (HFP) health plans.
Definition of Population Included in the Measure: A random sample of HFP members, ages 12 months through 18 years who were continuously enrolled in the plan during the measurement year and who had access to a primary care physician. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** A random sample of HFP members, ages 12 months through 18 years who were continuously enrolled in the plan during the measurement year and who had access to a primary care physician. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Inc** random sample of HFP member years who were continuously e measurement year and who h physician. Definition of denominator: ☒ Denominator includes SCHI ☐ Denominator includes SCHI Definition of numerator:
Year of Data: January – December 2003	**Year of Data:** January – December 2004	**Year of Data:** January – Decem

HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)*		**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)*		**HEDIS Performance Measure** *(If reporting with HEDIS/HEDI*
12-24 months Numerator: 6,827 Denominator: 7,306 Rate: 93%	7-11 years Numerator: 75,948 Denominator: 92,391 Rate: 82%	12-24 months Numerator: 8,129 Denominator: 8,904 Rate: 91%	7-11 years Numerator: 79,199 Denominator: 97,579 Rate: 81%	12-24 months Numerator: 7,868 Denominator: 8,476 Rate: 93%
25 months-6 years Numerator: 78,001 Denominator: 93,509 Rate: 83%	12-19 years: Not Collected Numerator: Denominator: Rate:	25 months-6 years Numerator: 92,350 Denominator: 113,441 Rate: 81%	12-19 years: Not Collected Numerator: Denominator: Rate:	25 months-6 years Numerator: 102,489 Denominator: 117,196 Rate: 87%
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:		**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:		**Other Performance Measuren** *(If reporting with another metho* Describe what is being measure Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress: For 2005: Based upon findings, plans with low scores continue to improve. Some scores have been impacted by poor methods of coll above 80% on HEDIS measures continue to have somewhat consistent high scores. Health plans are contacted for clarification if there is more than a 10% chan already been provided.

For 2006: Based upon the data submitted by the plans, it can be imputed that 87% of all applicable HFP enrollees had access to a primary care physician improvement of 7 percentage points from 2005.

Annual Performance Objective for FFY 2007: Working with plans to improve scores via Quality Performance Improvement Project. Participating health share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2008: Working with plans to improve scores via Quality Performance Improvement Project. Participating health share best practices and lower scoring plans submit a corrective action plan to improve these scores

Annual Performance Objective for FFY 2009: Working with plans to improve scores via Quality Performance Improvement Project. Participating health share best practices and lower scoring plans submit a corrective action plan to improve these scores

Explain how these objectives were set:

Other Comments on Measure:

1. WHAT OTHER STRATEGIES DOES YOUR STATE USE TO MEASURE AND REPORT ON ACCESS TO, QUALITY, OR OUTCOMES OF CARE RECEIVED BY YOUR SCHIP POPULATION? WHAT HAVE YOU FOUND?

MRMIB continues to obtain information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans include the following:

Fact Sheets: Fact Sheets are submitted annually by each health, dental and vision plan interested in participating in the HFP. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Specific areas addressed include:

- Access to providers,
- Obesity screening and education,
- Mental health and substance abuse services; and
- Process each plan uses to notify MRMIB of contractual arrangements that will impact the plan's provider network.

Annual Quality of Care Reports: Health and dental plans submit quality of care reports each year, as required in their HFP contracts. The Quality Improvement Work Group selects measures included in the reports for relevancy to the HFP population. Measures focus on preventative care and access because these areas are vital to young children and the cornerstone of the Program. The HEDIS® (Health Employer Data Information Set) is used as a basis for the current measures. The measures currently collected are:

- Childhood Immunization Status
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Adolescent Well-Care Visits
- Children's and Adolescent's Access to Primary Care Practitioners
- Follow-up After Hospitalization for Mental Illness
- Identification of Alcohol and Other Drug Services
- Use of Appropriate Medications for People with Asthma

The HEDIS® Mental Health Utilization Measure and Well-Child Visits during the First 15 Months of Life Measure have been added to the 2006-2007 Health Plan data reporting requirements. The HEDIS® Chlamydia Screening Measure has been added to the 2007-2008 Health Plan data reporting requirements.

HFP scores have remained better than Medicaid and comparable commercial plans for several years. The current mental illness measure will be replaced next year by the Mental Health Utilization (Inpatient, Intermediate, and Ambulatory Services) HEDIS® measure.

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California Children's Services (CCS) and Mental Health Referral Reports: The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. Plans are required to report the number of children referred to these services on a quarterly basis. The numbers reported by plans are compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services Report: This report allows staff to monitor how HFP subscribers' special needs related to language access and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How the Plan identifies the language preference of its members.
- The type of consideration taken by the Plan when using physician auto assignment or assigning culturally and linguistically appropriate providers, when a member has not selected a primary care physician.
- How the Plan informs its members of the availability of no cost interpretive services and how they provide this service to their subscribers and monitor their program.
- Methods that are used by the Plan to ensure language access at various points of contact.
- How Plans make available materials in non-English languages and the languages that are used in printing each document.
- How Plans ensure a sixth grade readability level for member documents (including translated documents).
- How Plans provide initial and continuing training on cultural competency to Plan staff and Plan network providers.

MRMIB staff developed and provided training for a new checklist in 2006 that provides consistency and clarity to the plans regarding their contractual Cultural and Linguistics requirements. MRMIB staff provided training to the Plans on how to use the checklist. The responses to the new checklist were received by MRMIB in early December 2006 and are currently being reviewed and tabulated.

Group Needs Assessment: The 2005-2008 HFP contract requires HFP plans to conduct a Group Needs Assessment (GNA) in 2007 to identify the health risks, beliefs, and develop work plans with timelines in order to address any needs that are identified. MRMIB will review the GNAs and work plans to determine the following:

- Subscriber identified needs
- Work plans and timelines ability to address identified subscriber needs

Plans, as part of their GNA, will assess the needs of their HFP subscribers in the following areas:

- Health related behaviors and practices
- Risk for disease, health problems, and conditions
- Knowledge, attitudes, beliefs, and practices related to access and use of preventive care
- Knowledge, attitudes, beliefs, and practices related to health risk
- Perceived health care and health education needs and expectations
- Cultural beliefs and practices related to alternative medicine
- Perceived language needs and preferred methods of learning
- Language needs and literacy level
- Community resources and capability to provide health education and cultural and linguistic services

Member Surveys: MRMIB uses two types of member surveys to monitor quality and service. All subscribers are given a plan disenrollment survey during open enrollment. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. For further information, please see Attachment A, Open Enrollment 2006 Survey Report.

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Consumer satisfaction surveys for both health and dental plans were conducted each year prior to 2004. MRMIB has presented the findings of these surveys in prior year Federal Annual Reports.

Funds were not allocated for these surveys in 2004 and 2005. Funds have recently been allocated and MRMIB has contracted with DataStat to conduct both the Health and Dental Consumer Assessment of Health Plans Surveys (CAHPS® 3.0H) and the Young Adult Health Care Survey (YAHCS). YAHCS is a survey given to 14 to 18 year olds to assess how well the health care system is providing recommended preventive care. The survey is administered by mail with an on-line response option and contains 57 questions related to aspects of care. The data obtained from YAHCS will be used for comparisons among plans, other programs and against data from the CAHPS.

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Data collection for both surveys began in March 2006. DataStat will prepare a report in 2007 based on that data. Information from the report will be provided in the 2007 Federal Annual Report.

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Subscriber Complaints: MRMIB receives direct inquiries and complaints regarding HFP benefits from subscribers. Approximately 90 percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquiries and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

2. What **strategies** does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

MRMIB has added performance measures to the 2005-2008 health and dental plan contracts. These performance measures include the following HEDIS® Measures:

- Mental Health Utilization (data will be available in 2007);
- Well Child Visits In The First 15 Months Of Life (data will be available in 2007); and
- Chlamydia Screening (data will be available in 2008)

Encounter/Claims Data: MRMIB is developing a process to collect encounter/claims data from health plans participating in the program. This data will broaden the scope and depth of quality of care information available to MRMIB and is intended for use in a number of reports and projects, including the Quality Performance Improvement Project discussed below. MRMIB's goal is that the data will be available in 2007.

Quality Performance Improvement Project: MRMIB applied a qualitative analysis of HEDIS scores in 2006 to review individual plan quality outcomes. MRMIB compared HEDIS 2004 scores with the HEDIS 2003 scores in the following four areas:

- Childhood Immunizations;
- Well Child Visits;
- Adolescent Well Care Visits; and
- Access to Primary Care Physicians,

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MRMIB aggregated scores for these measures, adjusted scores for improvements or declines and established a total plan score. Plans identified as "high performing plans" were contacted to discuss strategies and best practices which allowed them to achieve higher scores. Plans identified as "low performing plans" were provided theses strategies and best practices. The "low performing plans" are required to develop a corrective action plan to improve program scores. The Quality Performance Improvement Project will continue on an annual basis. Other quality measurements may be added at a later date to the review process.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

Mental Health/Substance Abuse Study: MRMIB has identified low utilization of mental health and substance abuse treatment services by HFP children. Given the complexity of the HFP delivery system for mental health and substance abuse services, MRMIB is conducting a three-phased project to evaluate the delivery of these services in the HFP:

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Phase I was completed in 2006 by researchers from the University of California, San Francisco. This Phase consisted of an evaluation of Serious Emotional Disturbance (SED) services provided through county mental health programs. The focus of this evaluation was to determine whether HFP subscribers are receiving adequate treatment services and to assess the adequacy of coordination of services between health plans and counties. The researchers for the Phase I study made a number of recommendations, including the following:

- Creation of a state-wide forum of health plans and county mental health departments to discuss issues related to referrals, assessment and treatment.
- Redesign of referral process
- Research and Development of standardized assessment tool
- Emphasis on early and periodic screening
- Increased Communication between counties, plans and providers

The results of the Phase I study are contained in Attachment ____.

Phase II and Phase III of the study will be conducted concurrently.

- Phase II will consist of an evaluation of mental health services provided by health plans, including issues that were identified as needing follow-up in Phase I of the study.
- Phase III will consist of an evaluation of substance abuse services provided by health plans, with special emphasis on services provided for co-occurring disorders.

A request for solicitation for the Phase II and Phase III study has been developed with responses required by February 21, 2007. The start date of the study contract is anticipated to be April 2007.

Health Status Assessment Project: Completed in 2004, the project evaluated the changes in health status of children newly enrolled in the HFP. The project examined the physical and psychosocial benefits of having access to comprehensive medical, dental and vision insurance. The Project was conducted with financial support from the David and Lucile Packard Foundation. Under the project, MRMIB implemented a longitudinal survey of families of children who were newly enrolled in the HFP in 2001 to measure changes in access to care and health status among these children over two years of enrollment.

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Results from this project showed:

- Dramatic, sustained improvements in health status for the children in the poorest health and significant, sustained increases for these children is paying attention in class and keeping up in school activities.
- Meaningful improvement in health status for the population at large.
- Increased access to care and reduced foregone health care for children in the poorest health and the population at large.

- A lack of significant variation by race and language in reports of no foregone care- the most significant variable associated with access.

The most significant improvements occurred after one year of enrollment in the program. These gains were sustained through the second year of enrollment. Because the survey does not quantify all factors that are attributable to changes in health status, it is not known how much of an impact changes in access to care has on the overall changes seen in health status. It is also not known what the underlying health status is of the children participating in this survey. The conclusion that can be made therefore is that the HFP contributes to the improvements in health status by increasing access to health care services.

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An article related to the Health Status Assessment Project entitled "The Impact of Realized Access to Care on Health-Related Quality of Life: A Two-Year Prospective Cohort Study of Children in the California State Children's Health Insurance Program" will be published in an upcoming issue of The Journal of Pediatrics.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings. **[7500]**

Attachments:

Open Enrollment 2006 Survey Report

2006 Annual Retention Report

Phase I Mental Health/Substance Abuse Study

2005 CHIS Preview Documents: "More than Half of California's Uninsured Children Eligible for Public Programs But not Enrolled" and "One in Five Californians Were Uninsured in 2005 Despite Modest Gains in Coverage"

2003 Health Status Assessment Project (PEDS QL)

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[7500]

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period? **[7500]**

   During the last quarter of this reporting period, outreach funding was recently restored to promote public awareness of the SCHIP and Medicaid programs. The $22 million funding allocation will occur on a county level to those counties where the highest number of eligible (but not enrolled) children reside and to counties that have the highest number of SCHIP and Medicaid enrollment in order to promote retention. The county allocations will build on the existing local structures, experience and knowledge gained by counties in their efforts to increase enrollment of uninsured children and program retention. County outreach utilizes a wide variety of community-based organizations that perform targeted outreach and enrollment activities to reach large number of children. Targeted, grassroots outreach activities require the counties to provide innovative and culturally appropriate outreach and enrollment approaches. While outreach funding was allocated during this reporting period, funding has not been distributed to the counties.

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   Effective July 1, 2006, the EE/CAA reimbursement process increased the amount for on-line applications submitted. For each successful on-line application where a child(ren) is enrolled (in SCHIP and for each application forwarded to the Medi-Cal program), the amount increased from $50 to $60. In addition, for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP, the EE receives $50 instead of $25.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., television, school outreach, word-of-mouth)? How have you measured effectiveness?

   The State determined that outreach through local community based organizations (i.e. EEs/CAAs) is important to reach the uninsured children and to promote program retention. These organizations (i.e. schools, faith-based organizations, social services agencies, health care provider communities, community clinics, etc.) create and establish relationships with families, promoting program awareness and providing assistance in applying for the programs. Past outreach efforts resulted in increased enrollment in the programs. After restoring the EE/CAA reimbursement process, the number of completed applications submitted significantly increased from 19% to 47.10% during the period of October 1, 2005 through July 31, 2006. As a result of EE/CAA assistance, 61.85% children who were enrolled in SCHIP (during the initial application process) obtained assistance from CAAs. In addition, the during the Annual Eligibility Review process, 12.67% of children continued to be eligible for SCHIP through the assistance of CAAs.

3. Is your State targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

   A small portion of the outreach funding will be allocated to the counties for specific target populations. The counties will develop their own approaches in promoting program awareness and retention. Past outreach efforts resulted in increased enrollment in the SCHIP and Medicaid programs.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of the FPL must complete question 1. All other States with trigger mechanisms should also answer this question.

1. Does your State cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

   ☒ Yes
   ☐ No
   ☐ N/A

   If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

   SCHIP does not maintain any trigger mechanisms. SCHIP precludes enrollment within 3 months of a child having employer-sponsored insurance (ESI).

States with separate child health programs over 250% of the FPL must complete question 2. All other States with substitution prevention provisions should also answer this question.

2. Does your State cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

   ☒ Yes
   ☐ No
   ☐ N/A

   If yes, identify your substitution prevention provisions (waiting periods, etc.).

   Under the provisions of the AB 495 SPA, Section 1.1, four counties are authorized to serve otherwise eligible children with incomes between 250-300% FPL, through their Healthy Kids Programs. These counties comply with the 3-month substitution coverage provision for ESI coverage. In addition, infants born to mothers who are enrolled in the California State AIM Program are automatically enrolled in SCHIP with coverage beginning on the infants' date of birth and may continue through age 2. These infants fall between 200% through 300% of the FPL. The infants are not subjected to any waiting period, since coverage begins on their date of birth.

All States must complete the following 3 questions.

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   The manner in which the State monitors and measures substitution of coverage has not changed since the inception of the program in 1998. Coverage substitution is monitored through the eligibility determination process and the collection of employer-sponsored insurance at the time of application data. Applicants are required to answer questions about each child's previous health coverage. The State also monitors this process through the State's plan partners who report and forward information to the State when a child is enrolled in SCHIP and had (or has) employer-sponsored coverage within the last 3 months. If the State receives this information, a formal ESI investigation is conducted.

   Children who received employer-based health coverage 3 months prior to application are not eligible for the HFP, unless they qualify for specific exemptions. These exemptions include the following items listed below.

   • The person or parent providing health coverage lost or changed jobs;

   • The family moved into an area where employer-sponsored coverage is not available;

- The employer discontinued health benefits to all employees;
- Coverage was lost because the individual providing the coverage died, legally separated, or divorced;
- COBRA coverage ended; or
- The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

4. At the time of application, what percent of applicants are found to have insurance? **[7500]**

   During the period of October 1, 2005 through September 30, 2006, over 5.9% of the children were determined to be ineligible at the time of initial application, as a result of having other insurance coverage. Of the 5.9% that had other insurance coverage, 0.3% had employer-sponsored insurance and over 5.6% were receiving health coverage through the no-cost Medi-Cal programs. For those children who were disenrolled during the Annual Eligibility Review (AER) process, over 5% of the children were determined to be ineligible because they had other insurance coverage. Of the 5% who were disenrolled during the AER process, .02% obtained employer-sponsored insurance, while over 5.05% were disenrolled because they were enrolled in the no-cost Medi-Cal programs.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

   Researchers from the University of California, San Francisco Institute for Health Policy Studies examined the level of substitution coverage for SCHIP. Their August 2002 study concluded that up to 8% of new applicants had employment-related insurance within the 3 months prior to enrolling in the HFP. The researchers found that the highest rate of substitution coverage occurred in the lower income group (below 200%) and that the single largest reason parents dropped employer-sponsored coverage was that it was unaffordable. More than a quarter of the group reported paying more than $75 per month.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program.)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain. **[7500]**

   The re-determination processes are similar; however, the re-determination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a re-determination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual re-determination month. If the child is found to be eligible for Medi-Cal, the child will continue to be enrolled in Medi-Cal for an additional twelve months. If the child is not eligible for Medi-Cal, the re-determination form is sent to SPE for a SCHIP eligibility determination, as long as there is parental consent. Failure to provide the completed annual re-determination form results in the discontinuance of benefits. However, should the beneficiary complete the annual re-determination required within 30 days of discontinuance, the discontinuance may be rescinded and benefits restored without a break in coverage. Please note that this process has not changed since the 2002 reporting period.

   In the SCHIP program, the applicant is mailed a customized, pre-printed Annual Eligibility Review (AER) package at least 60 days prior to their children's anniversary date. The AER package also has an attached Add-A-Person form which is used to apply for any children who now resides in the home but is not enrolled in SCHIP or Medicaid. If the AER package has not been returned within 30 days, the applicant is contacted by telephone to confirm receipt of the AER package, offer assistance to complete the package or to provide a referral to a local entity that can provide direct assistance to complete the AER package. The program also sends a reminder post card to the applicant,

explaining that the AER package is due and identifies the deadline date in which the program must receive the information. If the package is not received within 15 days from the deadline date, the applicant is sent a pending disenrollment letter and the reason for the disenrollment (e.g., no package returned, missing information requested not received, etc.). The pending disenrollment letter includes a Continued Enrollment (CE) form that can be used to appeal the decision. If the CE form is received prior to the prospective disenrollment date, coverage continues for an additional month or until the appeal is adjudicated. If the AER package is not received or is not completed by the end of the anniversary month, the children are disenrolled and the applicant is sent the appropriate disenrollment letter. All denial and disenrollment letters include a Program Review form to return to the program if the applicant disagrees with the adverse action.

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

   In Medi-Cal, if a subscriber is determined to be ineligible due to income (being too high) at the re-determination process, the application is forwarded to HFP (California's SCHIP Program), if the applicant has provided consent to forward the form to SCHIP. To improve the coordination between the two programs and ensure continuity of care, the State grants an additional one month of Medi-Cal continued coverage while the application is being processed for HFP eligibility.

   In the HFP, if a subscriber is determined ineligible due to income (being too low) at AER and the applicant has provided consent to forward to Medi-Cal, the AER application is forwarded to the county welfare department (CWD) in the county of the applicant's residence for a Medicaid eligibility determination. In the event the applicant does not initially provide consent to forward the AER application to the CWD, the HFP contacts the applicant to encourage him/her to re-consider Medi-Cal and to submit authorization to forward the AER application to the CWD. In these cases, coordination between the two programs and continuity of care are ensured by the State granting two additional months of HFP "bridge coverage" while the application is being processed for Medi-Cal eligibility or where the HFP is obtaining the applicant's consent to forward the AER application to the CWD.

   As part of the HFP bridge coverage, SCHIP uses a detailed transmittal sheet which accompanies each application forwarded to the CWD. This sheet provides detailed subscriber information such as, the income determination used to conclude that the subscriber's income is below SCHIP guidelines, the household composition and family relationships, and the unique identification number assigned to each child on the State's Medi-Cal Eligibility Data System (MEDS). The unique Client Index Number (CIN) provides California the ability to track HFP and Medi-Cal applications, enrollment, and eligibility status of children in either program or those being transferred between programs. If the CWD determines that a child is not eligible for no-cost Medi-Cal and may be eligible for the HFP, the transmittal sheet is returned to SCHIP. The transmittal sheet is accompanied with the application and all documentation for a HFP determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   Medicaid uses both managed care and fee-for-service providers, whereas SCHIP utilizes only managed care providers. There is a significant overlap in the managed care networks between Medicaid and SCHIP.

ELIGIBILITY RE-DETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

☒ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program?

  At least 3 notifications are sent to the families for the AER process. If families provide insufficient information in order to determine if their children continue to qualify, then, letters (in addition to those noted in the bullet below) are mailed to the families, informing them about what other information is needed. In these circumstances, phone calls are also made to the families.

- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)

  AER packet is sent 60 days before due date, 30-day reminder post-card is sent, courtesy calls are made if an AER is not returned 30 days prior to due date, and a pending disenrollment letter is sent 15 days prior to the disenrollment date. The pending disenrollment letter includes a Continued Enrollment (CE) form that can be used to appeal the decision. If the CE form is received prior to the prospective disenrollment, coverage continues for an additional month or until the appeal is adjudicated.

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☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups) **[500]**

☐ Holds information campaigns

☒ Provides a simplified reenrollment process

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Customized, pre-printed re-enrollment forms are available in 10 languages. The customized forms identify each family's information (i.e. known names and relationships of people living in the home). The forms are sent in the families' primary written languages.

☒ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:*

Thirty days after children are disenrolled, telephone surveys are made to the families to learn more about the specific reason why the coverage ended. If the families cannot be reached by telephone, then, disenrollment surveys are mailed to them.

☒ Other, *please explain*:

Effective July 1, 2006, the EE/CAA reimbursement increased the amount for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP. The EE receives $50 instead of $25.

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

   Currently, SCHIP does not have data measuring the effectiveness taken to retain eligible children.

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private

coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)?

☒ Yes
☐ No
☐ N/A

When was the monthly report or assessment last conducted?

September 2006

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

SCHIP monthly disenrollment reports are on the MRMIB website (www.mrmib.ca.gov). Charts can be found on avoidable (disenrollments that may be prevented) and unavoidable (disenrollments that cannot be prevented) disenrollments. In addition, in April 2006, the State conducted an annual retention report for the period of January 1, 2004 through December 31, 2004 which is also accessible through the MRMIB website.

The 2006 Annual Retention Report identifies the percentage of children initially enrolled in SCHIP and continued to qualify for an additional year. The retention rate was 77% in 2004, which is a 7% increase compared to the previous year. In 2004, 70% of the children remained enrolled in SCHIP. In 2002, 71% maintained enrollment. And, in 2001, only 69% remained enrolled.

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Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	Obtain other public or private coverage		Remain uninsured		Age-out		Move to new geographic area		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
258,482	7,837	3.03%	N/A	N/A	21,445	8.3%	N/A	N/A	N/A	N/A

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

The State assesses and reports a wide variety of enrollment and disenrollment related information on the MRMIB website (www.mrmib.ca.gov) on a monthly basis. This information also details the number and reasons children disenroll from SCHIP. These reasons include the number of children who are no longer eligible during the AER and the specific different reasons for disenrollment (i.e. turned 19 years old, obtained other insurance, income above/below the SCHIP guidelines, etc.). In addition, MRMIB conducts an annual Retention Report which details the reasons subscribers do not stay in the program. This report is also posted on the MRMIB website.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   California continues to use 2 surveys to assess the main reason why children disenroll from the HFP due to non-payment of premiums. The first survey is a post card that is mailed to every family after their child(ren)are disenrolled from the Program for non-payment of premiums. This survey includes questions about premiums and the cost of the Program. The family is asked to indicate which of the

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following reason best describes the reason they did not pay their premiums: 1) cannot afford payment, 2) lost invoices, 3) never received invoice, and 4) forgot to pay premium.

The second survey is in conjunction with the non-payment courtesy call initiated by the Program 10 days prior to disenrollment for non-payment of premium. During this call, the family is reminded that a premium payment is necessary in order to keep their child enrolled in the Program. If the family indicates they will not be making the payment, the Program attempts to establish the reason why the family is not able to make the payment. These reasons include those reasons (Items #1 - #4) noted in the above paragraph.

From responses to these surveys, the State has found that it is often the case that families who want to disenroll their child frequently quit paying their premium rather than providing the HFP with a formal written request for disenrollment. Both of these surveys are on a voluntary basis. However, based on both surveys it appears that only a very small percentage of those applicants who do respond are disenrolling from the Program because they cannot afford the cost of the monthly premium.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

   The State has not conducted an assessment of the effect of cost sharing on utilization of health services. However, many services provided in the HFP do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without co-payment. Copayments are also not required for services provide to children through the California Children's Services Program and the county mental health departments for children who are Seriously Emotionally Disturbed (SED).

3. If your State has increased or decreased cost sharing in the past federal fiscal year, has the State undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

   On July 1, 2005, the state increased monthly premiums up to $15 per child, with a maximum of $45 a month for families. Families who were subjected to the higher premium amount were those whose income was over 200% of the FPL. When the premium increase occurred, at that time, approximately 25% of existing families who had children enrolled in SCHIP were impacted by the higher premium. Families who were affected by the premium increase were sent notification about this change and given the opportunity to lower their premiums. The process to give families opportunities to lower their premiums continues to exist. When comparing the number of children who were disenrolled from SCHIP for non-payment of premiums before the premium increase with those children who were disenrolled after the premium increase, there was no significant impact on the number of children disenrolled because of the premium change. The percentage of children disenrolled for non-payment of premiums before the premium increase was 24.39%. Whereas, during this reporting period, 23.44% of children were disenrolled from SCHIP as a result of non-payment after the premium increase went into effect. The State has not performed any assessments on the impacts of the premium change on the application and enrollment processes, as well as the utilization if SCHIP health services.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

   ☐ Yes, please answer questions below.
   ☐ No, skip to Section IV.

Children

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan

- ☐ Family Coverage Waiver under the State Plan
- ☐ SCHIP Section 1115 Demonstration
- ☐ Medicaid Section 1115 Demonstration
- ☐ Health Insurance Flexibility & Accountability Demonstration
- ☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

- ☐ Yes, Check all that apply and complete each question for each authority.

- ☐ Premium Assistance under the State Plan (Incidentally)
- ☐ Family Coverage Waiver under the State Plan
- ☐ SCHIP Section 1115 Demonstration
- ☐ Medicaid Section 1115 Demonstration
- ☐ Health Insurance Flexibility & Accountability Demonstration
- ☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

   - ☐ Parents and Caretaker Relatives
   - ☐ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.) **[7500]**

4. What benefit package does the program use? **[7500]**

5. Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

   _____ Number of adults ever-enrolled during the reporting period

   _____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured? **[7500]**

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced? **[7500]**

9. During the reporting period, what accomplishments have been achieved in your premium assistance program? **[7500]**

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured? **[7500]**

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured? **[7500]**

13. Identify the total State expenditures for family coverage during the reporting period. **(For States offering premium assistance under a family coverage waiver only.) [7500]**

Enter any Narrative text below. **[7500]**

PROGRAM INTEGRITY

(This subsection should be completed by States with a Separate Child Health Program.)

1. Does your State have a written plan that has safeguards and establishes methods and procedures for prevention, investigation and referral of cases of fraud and abuse? Please explain:

   The State handles and reviews all issues related to fraud and abuse. The State does not rely on contractors to perform the fraud or abuse investigation. In the event plan partners, government entities or the general public alleges that fraud or abuse is being committed, the procedure is to report the information directly to the State. Most situations, where fraud allegations are being made, occur in circumstances where a child is currently enrolled in SCHIP and also has employer-sponsored insurance or when an absent parent indicates that the child resides with the absent parent. The State requires that the entity or individual reporting the fraud provide the information in writing and to include documentation to substantiate the allegations. The State reviews the allegations, conducts a formal investigation and contacts (by telephone and/or in writing) the individual who is allegedly committing the fraud or abuse.

   In 2002, the State conducted an independent fraud risk assessment for the SCHIP program. The assessment concluded that existing HFP rules and procedures are effective in deterring, detecting and controlling fraud and abuse among applicants. The analysis determined that the eligibility determination process establishes safeguards in preserving program integrity. Findings indicated that the applicant's income verification and documentation process reduced the likelihood of inappropriate enrollment.

   For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

   Provider Credentialing:

   0 Number of cases investigated

   0 Number of cases referred

   Provider Billing:

   0 Number of cases investigated

   0 Number of cases referred

   Beneficiary Eligibility:

   8 Number of cases investigated

   8 Number of cases referred

3. If your State relies on contractors to perform the above functions, how does your State provide oversight of those contractors? Please explain :

   The State contracts with various health, dental and vision plans that provide services to subscribers through a managed health care model. Each plan establishes safeguards for deterring, detecting and monitoring provider credentialing, fraud and abuse in accordance with State plan licensing statutes. The State pays the plans monthly capitation for each enrolled subscriber. Therefore, State oversight is provided through the plans' licensing agency, either Department of Managed Health Care or Department of Insurance.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period equals Federal Fiscal Year 2006. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

	2006	2007	2008
Benefit Costs			
Insurance Payments			
Managed Care	$1,060,844,172	$1,112,340,597	$1,242,699,6
per member/per month rate @ # of eligibles	$90	$88	$
Fee For Service	738,326,262	508,484,351	504,161,9
Total Benefit Costs	$1,799,170,434	$1,620,824,948	$1,746,860,4
(Offsetting beneficiary cost-sharing payments)	-67,369,084	-70,836,053	-75,682,7
Net Benefit Costs	1,731,801,350	1,549,988,894	1,671,178,2
Administration Costs			
Personnel			
General Administration	74,777,271	102,229,032	95,845,7
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing Costs	625,222	15,190,472	19,844,277
Other Indirect Costs			
Health Services Initiatives			
Total Administration Costs	**75,402,493**	**117,419,505**	**115,690,6**
10% Administrative Cap (net benefit costs ÷ 9)	**192,422,372**	**172,220,988**	**185,686,4**
Federal Title XXI Share	**1,150,872,123**	**1,064,009,572**	**1,141,658,**
State Share	**656,331,720**	**603,398,827**	**645,209,**
TOTAL COSTS OF APPROVED SCHIP PLAN	**1,807,203,843**	**1,667,408,399**	**1,786,868,**

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2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☒ County/local funds
- ☐ Employer contributions
- ☒ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify) **[500]**

Enter any Narrative text below. **[500]**

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children? **[500]**

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2006 starts 10/1/05 and ends 9/30/06).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2006	2007	2008	2009	2010
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed Care					
per member/per month rate @ # of eligibles					
Fee For Service					
Total Benefit Costs for Demonstration Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed Care					
per member/per month rate @ # of eligibles					

Fee For Service					
Total Benefit Costs for Demonstration Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)

Insurance Payments					
Managed Care					
per member/per month rate @ # of eligibles					
Fee For Service					
Total Benefit Costs for Demonstration Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)

Insurance Payments					
Managed Care					
per member/per month rate @ # of eligibles					
Fee For Service					
Total Benefit Costs for Demonstration Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost-Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost-Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing Costs					
Other *(specify)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)? **[500]**

Please provide a description of any assumptions that are included in your calculations. **[7500]**

Other notes relevant to the budget: **[7500]**

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

   There continues to be strong interest and support for coverage for children, both in the Administration and the Legislature even during a difficult fiscal situation. Governor Schwarzenegger's top priority in the coming legislative year is ensuring Californians have access to affordable health care with particular emphasis on children.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   Having enrolled approximately 90% of the eligible population, MRMIB must work harder to reach the remaining uninsured population through further outreach efforts and streamlining of enrollment.

3. During the reporting period, what accomplishments have been achieved in your program?

ENROLLMENT

The HFP is the largest SCHIP program in the country with 760,000 children enrolled, which is approximately 90% of the eligible children in California.

Prenatal SPA: California received approval from CMS for the Prenatal SPA on March 28, 2006. The SPA allowed California to draw down Title XXI funds for Medi-Cal and the AIM programs for certain prenatal services as of July 1, 2004.

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HFP Administrative Vendor Quality Standards: California has enacted the highest quality performance standards in the nation on its administrative vendor, at a 98% accuracy level. Along with the existing administrative performance standards that require timely processing, the new quality standards assure the accuracy of the administrative services provided by the vendor.

HFP Retention Increase: The HFP retention report for 2004 that was conducted in 2006 indicated increased retention rate for the HFP. The retention rate was 77% for the period of January-December 2004 which was about a 7% increase from the previous years (2001-69%; 2002-71%, and 2003-70%). This may be attributable to enhanced telephone follow-up requirements that were part of the new administrative vendor contract that was enacted in January 2004 and the outreach efforts by HFP plans and local community based organizations.

Enrollment Entity reimbursement incentive increase: On July 1, 2006 application assistance reimbursements were increased for successful Annual Eligibility Review Processes from $25 to $50 and successful electronic initial joint applications from $50 to $60.

QUALITY

Quality Performance Improvement Project: MRMIB applied a qualitative analysis of HEDIS scores in 2006 to review individual plan quality outcomes. MRMIB compared HEDIS 2004 scores with the HEDIS 2003 scores in the following four areas:

- Childhood Immunizations;
- Well Child Visits;
- Adolescent Well Care Visits; and
- Access to Primary Care Physicians,

MRMIB aggregated scores for these measures, adjusted scores for improvements or declines and established a total plan score. Plans identified as "high performing plans" were contacted to discuss

strategies and best practices which allowed them to achieve higher scores. Plans identified as "low performing plans" were provided theses strategies and best practices. The "low performing plans" are required to develop a corrective action plan to improve program scores. The Quality Performance Improvement Project will continue on an annual basis. Other quality measurements may be added at a later date to the review process.

Mental Health/Substance Abuse Study: MRMIB has identified low utilization of mental health and substance abuse treatment services by HFP children. Given the complexity of the HFP delivery system for mental health and substance abuse services, MRMIB is conducting a three-phased project to evaluate the delivery of these services in the HFP.

Phase I was completed in 2006 by researchers from the University of California, San Francisco. This Phase consisted of an evaluation of Serious Emotional Disturbance (SED) services provided through county mental health programs. The focus of this evaluation was to determine whether HFP subscribers are receiving adequate treatment services and to assess the adequacy of coordination of services between health plans and counties.

Phase II and Phase III of the study will be conducted concurrently in 2007.

- Phase II will consist of an evaluation of mental health services provided by health plans, including issues that were identified as needing follow-up in Phase I of the study.

- Phase III will consist of an evaluation of substance abuse services provided by health plans, with special emphasis on services provided for co-occurring disorders.

Oral Health Demonstration Project (OHDP)-The OHDP is a 3 year project that ended December 2006. MRMIB implemented the OHDP through its existing network of dental and health plans. The Insurance-based OHDP created an opportunity to review, evaluate and improve policies and procedures affecting the delivery and accessibility of oral health services for young children. A total of twenty-one projects served as models for improving preventive oral health measures and treatment for children who historically have been underserved. The University of California, San Francisco (UCSF) was hired to evaluate the projects and has submitted a draft report that is currently being reviewed by MRMIB.

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Six projects out of the original 21 projects were selected as models for improving preventive oral health measures and treatment for children who historically have been underserved. The projects agreed to provide best practices information including:

- Lessons learned by the project during its time of operation
- Work force issues
- Integration of medical and dental treatment
- Collaboration with partners
- Professional and consumer materials
- Methods of treatment including fluoride varnishes, sealants, xylitol
- Any policy issues identified by the projects
- Training in non- traditional settings and with special populations
- Methods used to deliver service to children with special needs

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These best practices will be posted on the MRMIB website to communicate opportunities to improve preventive oral health measures and treatment for children.

Rural Health Demonstration Projects (RHDP): The Department of Health and Human Services approved a State Plan amendment for California in December 1999 that included RHDP. The RHDP was established to improve access to health care services for medically underserved and uninsured populations in rural areas and special populations who have rural occupations (farm workers, loggers, etc.) The projects are used to enhance services, extend clinic hours and hire additional providers. The projects provide a number of services, including:

- Nutritional Counseling/Health Education

- Pediatric Surgery Centers
- Telemedicine
- Mental Health
- Tobacco Use
- Substance Abuse
- Dental Services
- Pediatric Weight Management

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OUTREACH

Certified Application Assistant (CAA) Online Web Based Training (WBT) (English/Spanish, Refresher WBT and # of CAAs trained): The existing online WBT for application assistance was expanded from English into Spanish on April 2006. In September 2006, MRMIB implemented a refresher WBT for CAAs that were interested in updating or reviewing their current program knowledge in both English and Spanish. To-date, MRMIB has trained approximately 1,500 CAAs statewide since the CAA WBT was implemented in February 2005.

COUNTIES

OERU County Allocation Grants: The July 2006 State Budget reinstated funding for the purpose of outreach, enrollment, retention and utilization. The funds are distributed through the California Department of Health Services to counties to support outreach activities by established community networks. The majority of funds are targeted towards the top twenty counties with eligible uninsured children and the smaller counties may apply for a set aside pool of funds from the larger counties.

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AB 495 Counties: Under the provisions of the AB 495 SPA, Section 1.1, four counties are authorized to serve otherwise eligible children with incomes between 250 – 300% FPL. California began drawing down Title XXI funds for three of the AB 495 counties.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

Enter any Narrative text below. **[7500]**

ENROLLMENT

Enrollment Streamlining (alternate plan assignment and no initial premium requirement): California is streamlining the enrollment process by no longer requiring a premium payment with the initial application process and also is eliminating the requirement that the applicant select their plans at initial application. HFP will no longer deny application for being incomplete for these two reasons beginning in January 2007. If the child(ren) is eligible, HFP will bill the family the required subscriber contribution. If no plans are selected and HFP cannot get a selection from the applicant within twenty days, we will enroll the eligible child in the community provider health plan and alternately assign the dental and vision plan.

Health-e-App Public Access: California is partnering with two private philanthropic foundations to expand the access of the existing electronic application. Currently only approved county workers and CAAs have access to the electronic application. The ongoing project to upgrade the existing electronic application will allow anyone with internet access to use the application to apply for HFP/MC. Expanded access plus the system edits that prevent certain application errors is anticipated to improve the success rate for applications submitted electronically.

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Presumptive Eligibility and Self-Certification: The State is scheduled to implement a SCHIP presumptive eligibility process to replace the Medi-Cal to HFP one-month bridge coverage. Currently, in the event a child who is enrolled in Medi-Cal no longer qualifies for the program, the child remains enrolled in Medi-Cal for one additional month until an SCHIP eligibility determination is made. The new process will replace the Medi-Cal one-month bridge coverage with SCHIP presumptive eligibility until the HFP conducts an eligibility determination. The new process will also establish self-certification of income during the SCHIP Annual Eligibility Review process, implement county pilot projects for Medi-Cal and establish an electronic gateway for the Women, Infants & Children (WIC) program.

HFP/MC Revised Joint Application: The long awaited revised joint application for HFP/MC will be implemented in the first quarter of 2007. This is the first major revision process on the joint application since it was revised in April 1999 and the revisions were made to simplify and improve the clarity of the application document for applicants.

HFP Open Enrollment (OE) Postcard Process: Less than 4% of HFP subscribers change plans during OE annually The HFP will be streamlining the open enrollment process in 2007 (April 15-May 31; with plan changes effective July 1). All subscribers will receive a postcard notification about OE and they can use that to request a customized OE packet to transfer plans.

QUALITY ENHANCEMENT

Quality Performance Improvement Project: MRMIB will continue, on an annual basis, to analyze HEDIS scores and monitor individual plan quality outcomes. The use of the high performing plans to provide strategies and best practices will also continue. The plans identified as "low performing plans" will be required to develop corrective action plans. Other quality measurements may be added at a later date to the review process.

Health Plan Contract Amendment: MRMIB amended the S-CHIP Health Plan contracts for the Budget Year beginning July 1, 2007 to reflect that MRMIB will evaluate each plan's clinical quality measures annually. The amendment also states that MRMIB will take appropriate action if MRMIB determines that the contractor's continued participation in the Healthy Families Program is not in the best interest of its subscribers.

OUTREACH

HFP Plan WBT: The online WBT for HFP plans that are approved to provide application assistance will be implemented in January 2007. While the training is similar to CAA training it is customized because of the statutory limitations on plan application assistance.

ATTACHMENTS

Attachment I: Open Enrollment 2006 Survey Report.

Attachment II: Healthy Families Program 2006 Report of Consumer Survey of Health Plans

Attachment III: Healthy Families Program 2006 Report of Consumer Survey of Dental Plans

Attachment IV: Healthy Families Program 2006 Report Of Young Adult Survey Of Health Plans (YACHS)

Attachment V: 2006 Annual Retention Report

Attachment VI: Healthy Families Program Health Status Assessment (PedsQL™) 2004

Attachment VII: California Health Interview Survey

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Deleted: Senate Bill 437 (Presumptive Eligibility (PE), Annual Eligibility Review self certification (AWER), Medi-Cal County pilot self certification, Women. Infants and Children gateway (WIC): SB 437 passed in 2006 and is pending a funding appropriation, which has been proposed in the Governor's budget. It provides for a PE process to replace the Medi-Cal to HFP one month bridge coverage process, establishes selfcertification for the HFP AER process, implements county pilot projects for a Medi-Cal process and establishes an electronic gateway for WIC. These administrative streamlining efforts are expected to be implemented in FY 2007/08.¶

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ATTACHMENT I:

HEALTHY FAMILIES PROGRAM
OPEN ENROLLMENT 2005
SURVEY REPORT

Open Enrollment 2006

Summary Report

Open Enrollment 2006

Overview

Subscribers with Option to change plans at 2006 OE Total = 745,218	Subscribers Who Voluntarily Changed plans	% of OE Eligible Total	Subscribers Who Were Required* to Change Plans	% of OE Eligible Total	Total Subscribers That Changed During OE	% of OE Eligible Total
Subscribers Changing Only Health Plans	11,161	1.50%	1,445	0.19%	12,606	1.69%
Subscribers Changing Only Dental Plans	12,551	1.68%	3,950	0.53%	16,501	2.21%
Subscribers Changing Only Vision Plans	504	0.07%	66	0.01%	570	0.08%
Subscriber Changing Both Health and Dental Plans	3,078	0.41%	579	0.08%	3,657	0.49%
Subscriber Changing Both Health and Vision Plans	582	0.08%	63	0.01%	645	0.09%
Subscriber Changing Both Dental and Vision Plans	804	0.11%	38	0.01%	842	0.11%
Subscriber Changing Health, Dental, and Vision Plans	990	0.13%	868	0.12%	1,858	0.25%
Total	29,670	3.98%	7,009	0.94%	36,679	4.92%

* Indicates subscribers whose plan was no longer available in their zip code.
* Data does not include Universal Care Health or Dental plans.

Open Enrollment Historical Data	1999	% of Total	2000	% of Total	2001	% of Total	2002	% of Total	2003	% of Total	2004	% of Total
Subscribers Changing Health Plans	3,827	3.00%	10,326	4.00%	14,566	3.00%	16,485	3.00%	36,903	6.00%	17,527	2.45%
Subscribers Changing Dental Plans	3,875	3.00%	8,005	3.00%	22,031	5.00%	12,142	2.00%	11,424	2.00%	10,882	1.52%
Subscribers With Option to Change Plans at OE **Total**	113,083		293,978		434,346		555,890		663,845		715,166	

Open Enrollment Historical Data	2005	% of Total
Subscribers Changing Health Plans	17,479	2.48%
Subscribers Changing Dental Plans	14,042	1.99%
Subscribers Changing Vision Plans	2,354	0.33%
Subscribers With Option to Change Plans at OE **Total**	704,183	100.00%

Data includes voluntary and required transfer requests

Satisfaction Survey: Overall Satisfaction Rating

On a scale of 1-5 (5 meaning Extremely Satisfied and 1 meaning Not At All Satisfied).
Responses are from families who voluntarily changed plans and from those families that were required to change plans. No families were required to change vision plans.

Health Plan Satisfaction	Dental Plan Satisfaction	Vision Plan Satisfaction
Average Satisfaction Score: 3.2	Average Satisfaction Score: 2.5	Average Satisfaction Score: 3.0
9,680 families responded to the Health Plan survey	15,277 families responded to the Dental Plan survey	2,028 families responded to the Vision Plan survey

Top Reasons Why Plan Transfers Were Requested

Responses are from families who voluntarily changed plans.

Health Plan Changes	Dental Plan Changes	Vision Plan Changes
1. Problem getting a doctor I'm happy with	1. Problem getting a Dentist I'm happy with	1. Appointments to see the optometrist have to be made too long in advance.
2. Appointments to see the doctor have to be made too long in advance.	2. Appointments to see the dentist have to be made too long in advance.	2. Problem getting an optometrist I'm happy with
3. Not being able to see a doctor when the need is urgent	3. Not satisfied with dental care received	3. Optometrist's office is too far away
4. Not Satisfied with the medical care received	4. Dentist's office is too far away	4. Not satisfied with vision care received
5. Problem getting a specialist when I need one	5. Not being able to see a dentist when the need is urgent	5. Problem getting care that I or my optometrist believed to be necessary

Open Enrollment 2006 Health Net HMO / Dental and Universal Care Plan Report

Note: All Universal Care members were given the opportunity to change during Open Enrollment.

Enrollment	Universal Care Health Plan		Universal Care Dental Plan	
	#	%	#	%
Total Starting Enrollment	**6,659**	**100.00%**	**60,640**	**100.00%**
Transferred to Plans Other Than Health Net*	**2,338**	**35.11%**	**17,524**	**28.90%**
Transferred to Health Net**	**4,321**	**64.89%**	**43,116**	**71.10%**

*Members who voluntarily selected another available plan.

**Members who did not return Open Enrollment packets were assigned to Health Net HMO / Dental.

Customer Satisfaction Survey Historical Data

Open Enrollment 1999-2006

Not all families responded to all of the questions. Responses are from families who voluntarily changed plans and from those families who were required to change plans.

Survey Question	Response	Extremely Satisfied (5)		Very Satisfied (4)		Satisfied (3)		Not Very Satisfied (2)		Not at all (1)		Average Score
		#	%	#	%	#	%	#	%	#	%	
Question 1 "How satisfied are you with the level of service you have received from your Health Plan?"												
1999	*	*		*		*		*		*		2.3
2000	*	*		*		*		*		*		3.4
2001	4,780	*		*		*		*		*		3.0
2002	4,742	569	12%	863	18%	1,683	35%	1,212	26%	415	9%	3.0
2003	6,785	793	12%	1,288	19%	2,568	38%	1,661	24%	475	7%	3.0
2004	4,998	741	15%	1,035	21%	1,966	39%	1,007	20%	249	5%	3.2
2005	5,873	1,085	18%	1,442	25%	2,018	34%	1,021	17%	307	5%	3.3
2006	9,680	1,430	15%	2,288	24%	3,683	38%	1,821	19%	458	5%	3.2
Question 4 "How satisfied are you with the level of service you have received from your medical group/clinic and the doctors and nurses who work there?"												
1999	*	*		*		*		*		*		2.3
2000	*	*		*		*		*		*		3.4
2001	4,559	*		*		*		*		*		3.1
2002	4,584	671	15%	871	19%	1,598	35%	1,010	22%	434	9%	3.1
2003	6,550	841	13%	1,266	19%	2,323	35%	1,541	24%	579	9%	3.0
2004	4,839	768	16%	1,034	21%	1,715	35%	961	20%	361	8%	3.2
2005	5,781	1,162	20%	1,460	25%	1,881	33%	929	16%	349	6%	3.4
2006	9,362	1,650	18%	2,279	24%	3,198	34%	1,668	18%	567	6%	3.3
Question 2 "How satisfied are you with the level of service you have received from your Dental Plan?"												
1999	*	*		*		*		*		*		1.5
2000	*	*		*		*		*		*		3.0
2001	6,895	*		*		*		*		*		2.2
2002	4,683	299	6%	384	8%	1,045	22%	1,603	34%	1,352	29%	2.3
2003	4,859	325	7%	461	9%	1,172	24%	1,590	33%	1,311	27%	2.4
2004	2,714	279	10%	673	25%	143	5%	412	15%	1,207	45%	2.4
2005	5,246	385	7%	556	11%	1,115	21%	1,752	33%	1,438	27%	2.4
2006	15,277	1,562	10%	2,451	16%	4,429	29%	3,988	26%	2,847	19%	2.5
Question 3 "How satisfied are you with the level of service you have received from your Vision Plan?"												
1999	Question Not Included On Survey											
2000	Question Not Included On Survey											
2001	7,973	*		*		*		*		*		3.7
2002	9,743	2,857	29%	2,800	29%	3,526	36%	368	4%	192	2%	3.7
2003	12,796	3,618	28%	3,935	31%	4,609	36%	406	3%	228	2%	3.8
2004	6,336	1,646	26%	1,932	30%	2,358	37%	301	5%	99	2%	3.7
2005	905	139	15%	189	21%	383	42%	141	16%	53	6%	3.2
2006	2,028	280	14%	415	20%	929	46%	285	14%	119	6%	3.0

* Data is not available

Health Plan Change Reasons Historical Data

Open Enrollment 1999-2006

Note - Applicant may have indicated more than one reason. Data includes voluntary and required transfer requests.

	1999		2000		2001		2002		2003		2004		2005		2006	
Reason	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases
Problem getting a doctor I'm happy with*	125	25%	719	20%	987	13%	1,555	14%	2,843	13%	1,552	11%	2,159	11%	3,427	11%
Appointments to see the doctor have to be made too long in advance.	63	13%	591	16%	651	9%	1,153	10%	1,827	8%	1,092	7%	1,858	10%	3,325	10%
Two weeks	**	**	**	**	**	**	**	**	725	3%	352	2%	854	5%	1,269	4%
Three weeks	**	**	**	**	**	**	**	**	400	2%	284	2%	530	3%	910	3%
Four weeks or more	**	**	**	**	**	**	**	**	702	3%	456	3%	474	3%	1,146	4%
Not being able to see a doctor when the need is urgent	**	**	**	**	723	10%	1,191	10%	2,457	11%	1,481	10%	1,321	7%	2,506	8%
Not satisfied with medical care received*	75	15%	719	20%	716	10%	1,090	10%	2,068	9%	1,320	9%	1,374	7%	2,359	7%
Problem getting a specialist when I need one*	36	7%	279	8%	520	7%	923	8%	1,771	8%	1,027	7%	1,345	7%	2,271	7%
Doctor's office is too far away. Check One:	67	14%	440	12%	503	7%	707	6%	1,298	6%	788	5%	1,251	7%	2,262	7%
1-5 miles	**	**	**	**	74	1%	81	1%	219	1%	130	1%	438	2%	903	3%
6-10 miles	**	**	**	**	136	2%	210	2%	384	2%	239	2%	368	2%	632	2%
10 miles or more	**	**	**	**	293	4%	416	4%	695	3%	419	3%	445	2%	727	2%
Not satisfied with the hours or days a primary care doctor's office is open*	18	4%	382	11%	350	5%	479	4%	1,351	6%	945	6%	930	5%	1,832	6%
Problem getting care that I or my doctor believed to be necessary	**	**	**	**	357	5%	604	5%	1,018	5%	587	4%	1,090	6%	1,824	6%
Problem getting help or advice during regular office hours	**	**	**	**	358	5%	616	5%	1,257	6%	819	6%	962	5%	1,719	5%
I do not like the condition of the doctor's office	**	**	**	**	**	**	**	**	**	**	722	5%	801	4%	1,442	4%
It took too long to receive laboratory results and diagnosis:	**	**	**	**	**	**	**	**	**	**	315	2%	668	4%	1,395	4%
Two weeks	**	**	**	**	**	**	**	**	**	**	98	1%	346	2%	724	2%
Three weeks	**	**	**	**	**	**	**	**	**	**	85	1%	163	1%	313	1%
Four weeks or more	**	**	**	**	**	**	**	**	**	**	132	1%	159	1%	358	1%
Primary care doctor left the plan	63	13%	201	6%	403	5%	610	5%	1,243	6%	710	5%	867	5%	1,296	4%
Not satisfied with the hospital network available	**	**	**	**	**	**	**	**	**	**	435	3%	499	3%	1,020	3%
I did not agree with the course of treatment	**	**	**	**	**	**	**	**	**	**	383	3%	578	3%	881	3%
Not satisfied with customer service at the plan level	**	**	**	**	**	**	**	**	**	**	438	3%	493	3%	865	3%
Medication not covered by the plan	**	**	**	**	**	**	**	**	**	**	396	3%	552	3%	880	3%
Authorization for a medical treatment was denied	**	**	**	**	**	**	**	**	**	**	201	1%	336	2%	566	2%
Children are discriminated against because they are enrolled in Healthy Families	18	4%	131	4%	132	2%	204	2%	316	1%	203	1%	349	2%	465	1%
I need an interpreter but doctor's office does not have one*	29	6%	124	3%	120	2%	172	2%	265	1%	232	2%	317	2%	457	1%
Optional benefits not available	**	**	**	**	**	**	**	**	**	**	181	1%	291	2%	294	1%
Other	**	**	**	**	1,086	15%	1,446	13%	4,533	20%	829	6%	793	4%	1,377	4%
Total	494	100%	3,586	100%	6,906	100%	10,750	100%	22,247	100%	14,656	100%	18,834	100%	32,463	100%

* In 2001 the wording of the question changed. The meaning is generally the same.

** The question was not included in that year's survey.

HEALTHY FAMILIES

Dental Plan Change Reasons Historical Data
Open Enrollment 1999-2006

Note - Applicant may have indicated more than one reason. Data includes voluntary and required transfer requests.

	1999		2000		2001		2002		2003		2004		2005		2006	
Reason	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases
Problem getting a Dentist I'm happy with*	233	49%	757	44%	2,343	15%	2,031	15%	1,900	17%	1,231	15%	2,832	13%	6,973	12%
Appointments to see the dentist have to be made too long in advance.	**	**	**	**	1,917	12%	1,679	13%	1,569	14%	883	10%	2,413	11%	6,721	12%
Two weeks	**	**	**	**	**	**	**	**	178	2%	75	1%	356	2%	965	2%
Three weeks	**	**	**	**	**	**	**	**	223	2%	133	2%	810	4%	1,390	2%
Four weeks or more	**	**	**	**	**	**	**	**	1,168	10%	675	8%	1,247	6%	4,366	8%
Not satisfied with dental care received	163	34%	618	36%	1,624	10%	1,469	11%	1,440	13%	901	11%	2,242	11%	5,465	10%
Dentist's office is too far away.	**	**	**	**	1,392	9%	1,068	8%	912	8%	650	8%	1,618	8%	4,367	8%
1-5 miles	**	**	**	**	121	1%	103	1%	125	1%	74	1%	356	2%	1,073	2%
6-10 miles	**	**	**	**	385	2%	281	2%	224	2%	175	2%	500	2%	1,330	2%
10 miles or more	**	**	**	**	886	6%	684	5%	563	5%	401	5%	762	4%	1,964	3%
Not being able to see a dentist when the need is urgent	**	**	**	**	1324	8%	973	7%	780	7%	573	7%	1,530	7%	3,916	7%
Problem getting care that I or my Dentist believed to be necessary	**	**	**	**	669	4%	625	5%	614	6%	373	4%	1,452	7%	3,551	6%
Primary care dentist left the plan	**	**	**	**	634	4%	457	3%	397	4%	368	4%	787	4%	3,412	6%
Problem getting a dental specialist when I need one*	77	16%	362	21%	1,083	7%	948	7%	853	8%	557	7%	1,292	6%	3,401	6%
I do not like the condition of the dentist's office	**	**	**	**	**	**	**	**	**	**	395	5%	1,054	5%	2,836	5%
Not satisfied with the hours or days a primary care dentist's office is open	**	**	**	**	587	4%	512	4%	466	4%	336	4%	1,178	6%	2,824	5%
Problem getting help or advice during regular office hours	**	**	**	**	478	3%	477	4%	417	4%	255	3%	903	4%	2,190	4%
I did not agree with the course of treatment	**	**	**	**	**	**	**	**	**	**	255	3%	764	4%	1,919	3%
Not satisfied with customer service at the plan level	**	**	**	**	**	**	**	**	**	**	366	4%	409	2%	1,521	3%
It took too long to receive laboratory results and diagnosis:	**	**	**	**	**	**	**	**	**	**	86	1%	332	2%	1,333	2%
Two weeks	**	**	**	**	**	**	**	**	**	**	17	0%	86	0%	493	1%
Three weeks	**	**	**	**	**	**	**	**	**	**	14	0%	107	1%	374	1%
Four weeks or more	**	**	**	**	**	**	**	**	**	**	55	1%	139	1%	466	1%
Children are discriminated against because they are enrolled in Healthy Families	**	**	**	**	342	2%	373	3%	317	3%	191	2%	498	2%	1,241	2%
Authorization for a dental treatment was denied	**	**	**	**	**	**	**	**	**	**	170	2%	386	2%	1,038	2%
I need an interpreter but dentist's office does not have one	**	**	**	**	343	2%	268	2%	217	2%	198	2%	440	2%	973	2%
Medication not covered by the plan	**	**	**	**	**	**	**	**	**	**	131	2%	332	2%	762	1%
Optional benefits not available	"	"	"	"	**	**	**	**	**	**	**	**	**	**	40	0%
Other	**	**	**	**	1,841	12%	1,352	10%	1,270	11%	530	6%	532	3%	2,631	5%
Total	473	100%	1,737	100%	14,577	100%	12,232	100%	11,152	100%	8,449	100%	20,994	100%	57,114	100%

* In 2001 the wording of the question changed. The meaning is generally the same.
** The question was not included in that year's survey.

Vision Plan Change Reasons Historical Data
Open Enrollment 1999-2006

Note - Applicant may have indicated more than one reason. Data includes voluntary and required transfer requests.

	1999-2004		2005		2006	
Reason	Number of Responses	% of Cases	Number of Responses	% of Cases	Number of Responses	% of Cases
Appointments to see the optometrist have to be made too long in advance.	**	**	139	13%	429	15%
Two weeks	**	**	60	6%	136	5%
Three weeks	**	**	41	4%	109	4%
Four weeks or more	**	**	38	4%	184	6%
Problem getting an optometrist I'm happy with	**	**	153	15%	384	13%
Optometrist's office is too far away. Check One:	**	**	112	11%	333	11%
1-5 miles	**	**	39	4%	112	4%
6-10 miles	**	**	28	3%	101	3%
10 miles or more	**	**	45	4%	120	4%
Not satisfied with vision care received*	**	**	102	10%	228	8%
Problem getting care that I or my optometrist believed to be necessary	**	**	64	6%	159	5%
Not being able to see a optometrist when the need is urgent	**	**	57	5%	157	5%
Problem getting a vision specialist when I need one	**	**	55	5%	153	5%
Not satisfied with the hours or days a primary care optometrist's office is open*	**	**	49	5%	125	4%
Primary care optometrist left the plan	**	**	34	3%	118	4%
It took too long to receive laboratory results and diagnosis:	**	**	34	3%	113	4%
Two weeks	**	**	20	2%	57	2%
Three weeks	**	**	8	1%	27	1%
Four weeks or more	**	**	6	1%	29	1%
Problem getting help or advice during regular office hours	**	**	32	3%	98	3%
I do not like the condition of the optometrist's office	**	**	36	3%	91	3%
I need an interpreter but optometrist's office does not have one*	**	**	28	3%	82	3%
Not satisfied with customer service at the plan level	**	**	24	2%	74	3%
Children are discriminated against because they are enrolled in Healthy Families	**	**	26	2%	62	2%
I did not agree with the course of treatment	**	**	33	3%	59	2%
Medication not covered by the plan	**	**	24	2%	52	2%
Authorization for a vision treatment was denied	**	**	17	2%	40	1%
Optional benefits not available	**	**	**	**	2	0%
Other	**	**	32	3%	151	5%
Total	**	**	1,051	100%	2,910	100%

* The option to change Vision Plans was not available until 2005.

** The question was not included in that year's survey. 2005 was the first year families could change vision plans.

Health, Dental, and Vision Plan Detail Data
Open Enrollment 2006

Not to Be Distributed to Board in Public

Healthy Families Program Open Enrollment Transfer Activity - By Health Plan 2006

Data includes voluntary and required transfer requests

Health Plan the Subscriber Transferred To	Alameda Alliance for Health	Blue Cross EPO	Blue Cross HMO	Blue Shield EPO	Blue Shield HMO	CalOptima	Care 1st Health Plan	Central Coast Alliance for Health	Community Health Group	Community Health Plan	Contra Costa Health Plan	Health Net HMO	Health Net Life EPO	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kaiser Permanente	Kern Family Health Care	L.A. Care Health Plan	Molina Healthcare	San Francisco Health Plan	Santa Barbara Regional Health Authority	Santa Clara Family Health Plan	Universal Care	Ventura County Health Care Plan	Enrollment by Plan of Members Participating in OE *	Percent of Enrollment by Plan of Members Participating in OE *	Percent Change During Open Enrollment
STARTING COUNT:	7,697	169,759	124,057	6,065	34,590	29,224	7,111	2,208	22,841	22,728	3,118	96,133	673	8,076	2,863	39,051	93,120	9,739	1,650	35,293	5,467	1,830	12,506	6,659	2,760	745,218		
Alameda Alliance for Health	7,459	5	24	-	5	-	-	-	-	-	3	9	-	-	-	-	8	-	-	-	1	-	-	-	-	7,514	1.0%	-2.38%
Blue Cross EPO	1	168,157	101	56	540	469	-	82	21	4	-	932	36	34	51	489	199	3	-	138	-	40	5	837	180	172,375	23.1%	1.54%
Blue Cross HMO	20	218	119,786	10	222	8	146	4	60	445	28	485	-	3	8	4	194	42	58	357	15	2	18	6	2	122,141	16.4%	-1.54%
Blue Shield EPO	0	33	48	5,963	3	-	-	4	40	-	-	32	2	-	-	-	6	-	-	116	-	-	-	-	-	6,247	0.8%	3.00%
Blue Shield HMO	1	64	245	-	32,266	43	13	-	-	92	-	127	-	-	-	35	49	-	2	32	1	4	11	157	3	33,145	4.4%	-4.18%
CalOptima	0	27	7	-	21	28,220	1	-	-	5	-	26	-	-	-	12	22	-	-	4	-	-	1	237	-	28,583	3.8%	-2.19%
Care 1st Health Plan	0	-	46	-	10	-	6,691	-	-	33	-	24	-	-	-	-	1	-	3	17	-	-	-	-	-	6,825	0.9%	-4.02%
Central Coast Alliance for Health	0	13	1	-	-	-	-	2,118	-	-	-	4	-	-	-	-	4	-	-	-	-	-	3	-	-	2,143	0.3%	-2.94%
Community Health Group	0	-	31	2	-	1	-	-	22,424	-	-	37	-	-	-	3	20	-	-	147	-	-	-	3	-	22,668	3.0%	-0.76%
Community Health Plan	0	-	41	2	10	8	15	-	2	21,133	-	15	-	-	-	13	1	-	-	13	-	-	-	2	-	21,255	2.9%	-6.48%
Contra Costa Health Plan	0	3	13	-	-	-	-	-	-	-	2,995	2	-	-	2	-	6	-	-	-	1	-	-	-	-	3,022	0.4%	-3.08%
Health Net HMO	21	95	1,176	2	663	86	59	-	13	379	20	92,630	-	10	-	69	126	46	8	255	3	7	29	4,321	6	100,024	13.4%	4.05%
Health Net Life EPO	0	6	4	-	-	-	2	-	-	-	-	-	635	-	-	-	-	-	-	-	-	-	-	-	-	647	0.1%	-3.86%
Health Plan of San Joaquin	3	28	7	-	5	-	-	-	-	-	-	5	-	7,923	-	-	13	-	-	-	-	-	2	-	-	7,986	1.1%	-1.11%
Health Plan of San Mateo	3	5	-	-	1	-	-	-	-	-	-	299	-	-	2,741	-	5	-	-	1	4	-	1	-	-	3,060	0.4%	6.88%
Inland Empire Health Plan	0	72	42	-	44	56	4	-	19	24	-	53	-	-	-	37,776	59	-	-	135	-	-	-	144	2	38,430	5.2%	-1.59%
Kaiser Permanente	189	962	2,187	25	728	317	164	-	188	526	72	1,321	-	106	57	587	92,329	172	57	913	26	-	149	843	2	101,920	13.7%	9.45%
Kern Family Health Care	0	26	103	-	3	3	-	-	1	4	-	33	-	-	-	4	17	9,476	-	2	-	-	-	-	-	9,672	1.3%	-0.69%
L.A. Care Health Plan	0	3	39	-	23	-	3	-	-	15	-	7	-	-	-	-	-	-	1,518	5	-	-	-	-	-	1,613	0.2%	0.00%
Molina Healthcare	0	27	87	5	30	10	13	-	73	66	-	73	-	-	-	59	44	-	4	33,157	-	1	-	103	-	33,752	4.5%	-4.37%
San Francisco Health Plan	0	3	10	-	-	-	-	-	-	-	-	2	-	-	2	-	5	-	-	-	5,416	-	-	-	-	5,438	0.7%	-0.53%
Santa Barbara Regional Health Authority	0	6	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,776	-	-	-	1,783	0.2%	-2.57%
Santa Clara Family Health Plan	0	4	58	-	13	3	-	-	-	2	-	16	-	-	2	-	12	-	-	1	-	-	12,287	-	-	12,398	1.7%	-0.86%
Universal Care	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0.0%	-100.00%
Ventura County Health Care Plan	0	2	-	-	3	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	6	2,565	2,577	0.3%	-6.63%

* Excludes disenrollments

Total Subscribers Changing Plans at OE:	27,777
Percent of Subscribers Changing Plans at OE:	3.73%

ENDING COUNT:	745,218	100.0%

Healthy Families Program Open Enrollment Transfer Activity - By Health Plan 2006

Data includes voluntary transfer requests

Health Plan the Subscriber Transferred To	Alameda Alliance for Health	Blue Cross EPO	Blue Cross HMO	Blue Shield EPO	Blue Shield HMO	CalOptima	Care 1st Health Plan	Central Coast Alliance for Health	Community Health Group	Community Health Plan	Contra Costa Health Plan	Health Net HMO	Health Net Life EPO	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kaiser Permanente	Kern Family Health Care	L.A. Care Health Plan	Molina Healthcare	San Francisco Health Plan	Santa Barbara Regional Health Authority	Santa Clara Family Health Plan	Universal Care	Ventura County Health Care Plan	Enrollment by Plan of Members Participating in OE*	Percent of Enrollment by Plan of Members Participating in OE*	Percent Change During Open Enrollment
STARTING COUNT:	7,697	169,759	124,057	6,065	34,590	29,224	7,111	2,208	22,841	22,728	3,118	96,133	673	8,076	2,863	39,051	93,120	9,739	1,650	35,293	5,467	1,830	12,506	6,659	2,760	745,218			* Excludes disenrollments
Alameda Alliance for Health	7,459	-	24	-	5	-	-	-	-	-	-	9	-	-	-	-	8	-	-	-	-	-	-	-	-	7,505	1.0%	-2.49%	
Blue Cross EPO	-	168,157	25	54	530	456	-	79	20	1	-	636	36	32	43	451	172	-	-	137	-	39	2	-	168	171,038	23.0%	0.75%	
Blue Cross HMO	19	10	119,786	10	222	1	146	-	57	444	26	483	-	-	3	2	194	41	55	357	13	2	18	-	2	121,891	16.4%	-1.75%	
Blue Shield EPO	-	15	42	5,963	-	-	-	-	38	-	-	32	2	-	-	-	6	-	-	116	-	-	-	-	-	6,214	0.8%	2.46%	
Blue Shield HMO	1	42	238	-	32,266	40	13	-	-	92	-	124	-	-	-	29	46	-	2	32	1	4	11	-	3	32,944	4.4%	-4.76%	
CalOptima	-	27	3	-	21	28,220	-	-	-	-	-	26	-	-	-	4	22	-	-	-	-	-	-	-	-	28,323	3.8%	-3.08%	
Care 1st Health Plan	-	0	46	-	10	-	6,691	-	-	33	-	24	-	-	-	-	1	-	3	17	-	-	-	-	-	6,825	0.9%	-4.02%	
Central Coast Alliance for Health	-	13	-	-	-	-	-	2,118	-	-	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	2,135	0.3%	-3.31%	
Community Health Group	-	0	31	2	-	-	-	-	22,424	-	-	37	-	-	-	-	19	-	-	147	-	-	-	-	-	22,660	3.0%	-0.79%	
Community Health Plan	-	0	41	2	10	-	15	-	-	21,133	-	15	-	-	-	-	-	-	-	13	-	-	-	-	-	21,229	2.8%	-6.60%	
Contra Costa Health Plan	-	0	13	-	-	-	-	-	-	-	2,995	2	-	-	-	-	6	-	-	-	-	-	-	-	-	3,016	0.4%	-3.27%	
Health Net HMO	19	55	1,172	2	660	81	59	-	13	368	20	92,630	-	8	-	62	121	43	8	255	3	7	18	-	5	95,609	12.8%	-0.55%	
Health Net Life EPO	-	0	-	-	-	-	2	-	-	-	-	-	635	-	-	-	-	-	-	-	-	-	-	-	-	637	0.1%	-5.35%	
Health Plan of San Joaquin	-	27	-	-	5	-	-	-	-	-	-	5	-	7,923	-	-	13	-	-	-	-	-	-	-	-	7,973	1.1%	-1.28%	
Health Plan of San Mateo	1	5	-	-	1	-	-	-	-	-	-	-	-	-	2,741	-	5	-	-	-	2	-	-	-	-	2,755	0.4%	-3.77%	
Inland Empire Health Plan	-	71	-	-	38	4	2	-	15	1	-	43	-	-	-	37,776	48	-	-	135	-	-	-	-	-	38,133	5.1%	-2.35%	
Kaiser Permanente	179	870	2,167	24	728	301	159	-	188	524	69	1,266	-	101	56	557	92,329	172	57	912	25	-	141	-	-	100,825	13.5%	8.27%	
Kern Family Health Care	-	4	103	-	-	-	-	-	-	-	-	33	-	-	-	-	15	9,476	-	-	-	-	-	-	-	9,631	1.3%	-1.11%	
L.A. Care Health Plan	-	0	28	-	23	-	3	-	-	15	-	7	-	-	-	-	-	-	1,518	2	-	-	-	-	-	1,596	0.2%	0.00%	
Molina Healthcare	-	21	84	5	28	4	13	-	71	66	-	73	-	-	-	43	44	-	4	33,157	-	1	-	-	-	33,614	4.5%	-4.76%	
San Francisco Health Plan	-	0	10	-	-	-	-	-	-	-	-	2	-	-	-	-	4	-	-	-	5,416	-	-	-	-	5,432	0.7%	-0.64%	
Santa Barbara Regional Health Authority	-	6	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,776	-	-	-	1,783	0.2%	-2.57%	
Santa Clara Family Health Plan	-	1	58	-	13	-	-	-	-	-	-	16	-	-	-	-	12	-	-	-	-	-	12,287	-	-	12,387	1.7%	-0.95%	
Universal Care	-	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0.0%	-100.00%	
Ventura County Health Care Plan	-	2	-	-	3	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	2,565	2,571	0.3%	-6.85%	

Total Subscribers Changing Plans at OE:	19,285
Percent of Subscribers Changing Plans at OE:	2.59%

ENDING COUNT:	745,218	100.0%

HEALTHY FAMILIES

Healthy Families Program Open Enrollment Transfer Activity - By Health Plan 2006

Data includes required transfer requests

Health Plan the Subscriber Transferred To	Alameda Alliance for Health	Blue Cross EPO	Blue Cross HMO	Blue Shield EPO	Blue Shield HMO	CalOptima	Care 1st Health Plan	Central Coast Alliance for Health	Community Health Group	Community Health Plan	Contra Costa Health Plan	Health Net HMO	Health Net Life EPO	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kaiser Permanente	Kern Family Health Care	L.A. Care Health Plan	Molina Healthcare	San Francisco Health Plan	Santa Barbara Regional Health Authority	Santa Clara Family Health Plan	Universal Care	Ventura County Health Care Plan	Enrollment by Plan of Members Participating in OE *	Percent of Enrollment by Plan of Members Participating in OE *	Percent Change During Open Enrollment
STARTING COUNT:	7,697	169,759	124,057	6,065	34,590	29,224	7,111	2,208	22,841	22,728	3,118	96,133	673	8,076	2,863	39,051	93,120	9,739	1,650	35,293	5,467	1,830	12,506	6,659	2,760	745,218			* Excludes disenrollments
Alameda Alliance for Health	7,459	5	-	-	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-	-	1	-	-	-	-	7,468	1.0%	-2.98%	
Blue Cross EPO	1	168,157	76	2	10	13	-	3	1	3	-	296	-	2	8	38	27	3	-	1	-	1	3	837	12	169,494	22.7%	-0.16%	
Blue Cross HMO	1	208	119,786	-	-	7	-	4	3	1	2	2	-	3	5	2	-	1	3	-	2	-	-	6	-	120,036	16.1%	-3.24%	
Blue Shield EPO	-	18	6	5,963	3	-	-	4	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5,996	0.8%	-1.14%	
Blue Shield HMO	-	22	7	-	32,266	3	-	-	-	-	-	3	-	-	-	6	3	-	-	-	-	-	-	157	-	32,467	4.4%	-6.14%	
CalOptima	-	-	4	-	-	28,220	1	-	-	5	-	-	-	-	-	8	-	-	-	4	-	-	1	237	-	28,480	3.8%	-2.55%	
Care 1st Health Plan	-	-	-	-	-	-	6,691	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6,691	0.9%	-5.91%	
Central Coast Alliance for Health	-	-	1	-	-	-	-	2,118	-	-	-	-	-	-	-	-	4	-	-	-	-	-	3	-	-	2,126	0.3%	-3.71%	
Community Health Group	-	-	-	-	-	1	-	-	22,424	-	-	-	-	-	-	3	1	-	-	-	-	-	-	3	-	22,432	3.0%	-1.79%	
Community Health Plan	-	-	-	-	-	8	-	-	2	21,133	-	-	-	-	-	13	1	-	-	-	-	-	-	2	-	21,159	2.8%	-6.90%	
Contra Costa Health Plan	-	3	-	-	-	-	-	-	-	-	2,995	-	-	-	2	-	-	-	-	-	1	-	-	-	-	3,001	0.4%	-3.75%	
Health Net HMO	2	40	4	-	3	5	-	-	-	11	-	92,630	-	2	-	7	5	3	-	-	-	-	11	4,321	1	97,045	13.0%	0.95%	
Health Net Life EPO	-	6	4	-	-	-	-	-	-	-	-	-	635	-	-	-	-	-	-	-	-	-	-	-	-	645	0.1%	-4.16%	
Health Plan of San Joaquin	3	1	7	-	-	-	-	-	-	-	-	-	-	7,923	-	-	-	-	-	-	-	-	2	-	-	7,936	1.1%	-1.73%	
Health Plan of San Mateo	2	-	-	-	-	-	-	-	-	-	-	299	-	-	2,741	-	-	-	-	1	2	-	1	-	-	3,046	0.4%	6.39%	
Inland Empire Health Plan	-	1	42	-	6	52	2	-	4	23	-	10	-	-	-	37,776	11	-	-	-	-	-	-	144	2	38,073	5.1%	-2.50%	
Kaiser Permanente	10	92	20	1	-	16	5	-	-	2	3	55	-	5	1	30	92,329	-	-	1	1	-	8	843	2	93,424	12.5%	0.33%	
Kern Family Health Care	-	22	-	-	3	3	-	-	1	4	-	-	-	-	-	4	2	9,476	-	2	-	-	-	-	-	9,517	1.3%	-2.28%	
L.A. Care Health Plan	-	3	11	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,518	3	-	-	-	-	-	1,535	0.2%	0.00%	
Molina Healthcare	-	6	3	-	2	6	-	-	2	-	-	-	-	-	-	16	-	-	-	33,157	-	-	-	103	-	33,295	4.5%	-5.66%	
San Francisco Health Plan	-	3	-	-	-	-	-	-	-	-	-	-	-	-	2	-	1	-	-	-	5,416	-	-	-	-	5,422	0.7%	-0.82%	
Santa Barbara Regional Health Authority	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,776	-	-	-	1,776	0.2%	-2.95%	
Santa Clara Family Health Plan	-	3	-	-	-	3	-	-	-	2	-	-	-	-	2	-	-	-	-	1	-	-	12,287	-	-	12,298	1.7%	-1.66%	
Universal Care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	0	0.0%	-100.00%	
Ventura County Health Care Plan	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6	2,565	2,571	0.3%	-6.85%	

Total Subscribers Changing Plans at OE:	8,492
Percent of Subscribers Changing Plans at OE:	1.14%

ENDING COUNT:	745,218	100.0%

Healthy Families Program Open Enrollment Transfer Activity - By Dental Plan

Data includes voluntary and required transfer requests

Dental Plan the Subscriber Transferred To	Access Dental	Delta Dental	Health Net Dental	Premier Access	SafeGuard Dental	Universal Care Dental	Western Dental	Enrollment by Plan of Members Participating in OE *	Percent of Enrollment by Plan of Members Participating in OE *	Percent Change During Open Enrollment
STARTING COUNT:	**129,182**	**360,805**	**0**	**19,063**	**141,561**	**60,640**	**33,967**	**745,218**		
Access Dental	120,956	156		7	758	2,585	276	**124,738**	**16.7%**	**-3.44%**
Delta Dental	4,242	359,308		455	3,711	3,744	878	**372,338**	**50.0%**	**3.20%**
Health Net Dental	373	24	0		490	43,116	75	**44,078**	**5.9%**	**100.00%**
Premier Access	7	740		18,565	273	3	166	**19,754**	**2.7%**	**3.62%**
SafeGuard Dental	1,539	129		4	134,403	3,934	340	**140,349**	**18.8%**	**-0.86%**
Universal Care Dental						0		**0**	**0.0%**	**-100.00%**
Western Dental	2,065	448		32	1,926	7,258	32,232	**43,961**	**5.9%**	**68.23%**

*** Excludes Disenrollments**

Total Subscribers Changing Plans at OE:	**79,754**
Percent of Subscribers Changing Plans at OE:	**10.70%**

ENDING COUNT:		**745,218**	**100%**

Healthy Families Program Open Enrollment Transfer Activity - By Vision Plan

Data includes voluntary and required transfer requests

Vision Plan the Subscriber Transferred To	Eye MED Vision Care	SafeGuard Vision	Vision Service Plan	Enrollment by Plan of Members Participating in OE *	Percent of Enrollment by Plan of Members Participating in OE *	Percent Change During Open Enrollment
STARTING COUNT:	21,670	22,626	700,922	**745,218**		
EyeMed Vision Care	21,437	130	2,826	**24,393**	**3.3%**	**12.57%**
SafeGuard Vision	50	22,220	2,213	**24,483**	**3.3%**	**8.21%**
VSP	183	276	695,883	**696,342**	**93.4%**	**-0.65%**

* Excludes Disenrollments

Total Subscribers Changing Plans at OE:	**5,039**
Percent of Subscribers Changing Plans at OE:	**0.68%**

ENDING COUNT:	**745,218**	**100.0%**

Customer Satisfaction Survey Results by Health Plan

Open Enrollment 2006

Not all families responded to all of the questions.

Responses are from families who voluntarily changed plans and from those families who were required to change plans.

Health Plan the Family Transferred Out Of	Question 1	
	Average Score	Number of Families Responding
Universal Care	3.7	1,277
San Francisco Health Plan	3.5	21
Blue Shield EPO	3.5	45
Blue Cross EPO	3.5	640
Health Net HMO	3.3	1,340
Ventura County Health Care Plan	3.3	61
Central Coast Alliance for Health	3.3	29
Santa Clara Family Health Plan	3.3	92
Health Plan of San Joaquin	3.3	58
Alameda Alliance for Health	3.2	103
Inland Empire Health Plan	3.2	470
CalOptima	3.2	357
Blue Shield HMO	3.2	921
Blue Cross HMO	3.2	1,776
Health Plan of San Mateo	3.2	42
Community Health Plan	3.1	652
L.A. Care Health Plan	3.1	58
Care1st Health Plan	3.1	168
Santa Barbara Regional Health Authority	3.1	23
Kern Family Health Care	3.1	104
Kaiser Permanente	3.0	304
Community Health Group	3.0	166
Molina Healthcare	2.9	911
Contra Costa Health Plan	2.9	48
Health Net Life EPO	2.6	14
Average/Total	**3.2**	**9,680**

Health Plan the Family Transferred Out Of	Question 4	
	Average Score	Number of Families Responding
Universal Care	3.7	1,250
Blue Shield EPO	3.7	46
Health Net Life EPO	3.6	14
Blue Cross EPO	3.5	625
Central Coast Alliance for Health	3.5	25
Santa Barbara Health Authority	3.5	22
Health Net HMO	3.3	1,287
Blue Shield HMO	3.3	890
Ventura County Health Care Plan	3.3	60
San Francisco Health Plan	3.3	20
Alameda Alliance for Health	3.2	100
Molina Healthcare	3.2	891
CalOptima	3.2	343
Inland Empire Health Plan	3.2	461
Community Health Plan	3.2	620
Health Plan of San Joaquin	3.1	57
Care1st Health Plan	3.1	161
Blue Cross HMO	3.1	1,708
Kaiser Permanente	3.1	294
Health Plan of San Mateo	3.1	38
Community Health Group	3.1	167
Santa Clara Family Health Plan	3.0	83
Kern Family Health Care	3.0	102
L.A. Care Health Plan	3.0	52
Contra Costa Health Plan	2.9	46
Average/Total	**3.2**	**9,362**

Legend

Questions:

Question 1 - How satisfied are you with the level of service you have received from your health plan (Choice of doctors, written materials, customer service)?

Question 4 - How satisfied are you with the level of service you have received from your medical group/clinic and the doctors and nurses who work there?

Scale:

1 = Not At All
2 = Not Very Satisfied
3 = Satisfied
4 = Very Satisfied
5 = Extremely Satisfied

HEALTHY FAMILIES

Customer Satisfaction Survey Data by Health Plan

Open Enrollment 2006

Not all families responded to all of the questions.

Responses are from families who voluntarily changed plans and from those families who were required to change plans.

Survey Question	Number of Families Responding	Extremely Satisfied (5)	Very Satisfied (4)	Satisfied (3)	Not Very Satisfied (2)	Not at all (1)	Average Score
Question 1 "How satisfied are you with the level of service you have received from your Health Plan?"							
Universal Care	1,277	289	403	490	78	17	3.7
San Francisco Health Plan	21	6	4	7	3	1	3.5
Blue Shield EPO	45	12	10	14	7	2	3.5
Blue Cross EPO	640	133	169	229	88	21	3.5
Health Net HMO	1,340	222	315	497	253	53	3.3
Ventura County Health Care Plan	61	7	16	26	11	1	3.3
Central Coast Alliance for Health	29	4	8	11	4	2	3.3
Santa Clara Family Health Plan	92	15	20	36	17	4	3.3
Health Plan of San Joaquin	58	10	8	29	9	2	3.3
Alameda Alliance for Health	103	8	32	41	21	1	3.2
Inland Empire Health Plan	470	63	106	183	99	19	3.2
CalOptima	357	47	83	135	79	13	3.2
Blue Shield HMO	921	139	216	319	183	64	3.2
Blue Cross HMO	1,776	235	387	693	385	76	3.2
Health Plan of San Mateo	42	8	7	13	12	2	3.2
Community Health Plan	652	65	149	265	142	31	3.1
L.A. Care Health Plan	58	8	14	17	14	5	3.1
Care1st Health Plan	168	20	31	67	44	6	3.1
Santa Barbara Regional Health Authority	23	1	8	8	4	2	3.1
Kern Family Health Care	104	11	19	48	17	9	3.1
Kaiser Permanente	304	29	60	132	62	21	3.0
Community Health Group	166	16	33	68	36	13	3.0
Molina Healthcare	911	75	183	333	233	87	2.9
Contra Costa Health Plan	48	5	7	18	13	5	2.9
Health Net Life EPO	14	2		4	7	1	2.6
Total	**9,680**	**1,430**	**2,288**	**3,683**	**1,821**	**458**	3.2

Customer Satisfaction Survey Data by Health Plan

Open Enrollment 2006

Not all families responded to all of the questions.

Responses are from families who voluntarily changed plans and from those families who were required to change plans.

Survey Question	Number of Families Responding	Extremely Satisfied (5)	Very Satisfied (4)	Satisfied (3)	Not Very Satisfied (2)	Not at all (1)	Average Score
Question 4 "How satisfied are you with the level of service you have received from your medical group/clinic and the doctors and nurses who							
Universal Care	1,250	285	452	403	88	22	3.7
Blue Shield EPO	46	14	10	16	5	1	3.7
Health Net Life EPO	14	3	5	4	1	1	3.6
Blue Cross EPO	625	141	156	213	95	20	3.5
Central Coast Alliance for Health	25	5	5	13	1	1	3.5
Santa Barbara Health Authority	22	4	8	4	6		3.5
Health Net HMO	1,287	238	327	411	249	62	3.3
Blue Shield HMO	890	194	205	265	153	73	3.3
Ventura County Health Care Plan	60	8	17	23	9	3	3.3
San Francisco Health Plan	20	4	4	6	5	1	3.3
Alameda Alliance for Health	100	15	24	35	22	4	3.2
Molina Healthcare	891	150	211	294	167	69	3.2
CalOptima	343	55	74	133	56	25	3.2
Inland Empire Health Plan	461	84	94	154	91	38	3.2
Community Health Plan	620	86	145	226	129	34	3.2
Health Plan of San Joaquin	57	8	12	20	14	3	3.1
Care1st Health Plan	161	26	28	57	42	8	3.1
Blue Cross HMO	1,708	237	347	622	364	138	3.1
Kaiser Permanente	294	29	67	122	58	18	3.1
Health Plan of San Mateo	38	8	2	16	10	2	3.1
Community Health Group	167	20	41	51	40	15	3.1
Santa Clara Family Health Plan	83	12	14	30	18	9	3.0
Kern Family Health Care	102	16	12	40	24	10	3.0
L.A. Care Health Plan	52	4	12	20	10	6	3.0
Contra Costa Health Plan	46	4	7	20	11	4	2.9
Total	**9,362**	**1,650**	**2,279**	**3,198**	**1,668**	**567**	3.2

Open Enrollment 2006

Customer Satisfaction Survey Results by Dental Plan		
Not all families responded to all of the questions.		
Responses are from families who voluntarily changed plans and from those families who were required to change plans.		
Dental Plan the family Transferred from	Question 2	
	Average Score	Number of Families Responding
Universal Care Dental	3.1	8,205
Delta Dental	2.8	593
Premier Access	2.4	179
SafeGuard Dental	2.4	2,478
Access Dental	2.3	3,156
Western Dental	2.2	666
Average/Total	**2.5**	**15,277**

Customer Satisfaction Survey Results by Vision Plan		
Not all families responded to all of the questions.		
Responses are from families who voluntarily changed plans and from those families who were required to change plans.		
Vision Plan	Question 3	
	Average Score	Number of Families Responding
Vision Service Plan	3.3	1,832
Eye MED Vision Care	3.0	80
SafeGuard Vision	2.8	116
Total	**3.0**	**2,028**

Legend	
Questions:	
Question 2 - How satisfied are you with the level of service you have received from your dental plan? (Choice of dentists, written materials, customer service)	
Question 3 - How satisfied are you with the level of service you have received from your vision plan? (Choice of vision doctors, written materials, customer service)	
Scale:	
1 = Not At All	4 = Very Satisfied
2 = Not Very Satisfied	5 = Extremely Satisfied
3 = Satisfied	

Customer Satisfaction Survey Data by Dental and Vision Plan

Open Enrollment 2006

Not all families responded to all of the questions.

Responses are from families who voluntarily changed plans and from those families who were required to change plans.

Survey Question	Number of Families Responding	Extremely Satisfied (5)	Very Satisfied (4)	Satisfied (3)	Not Very Satisfied (2)	Not at all (1)	Average Score
Question 2 *"How satisfied are you with the level of service you have received from your Dental Plan?"*							
Universal Care Dental	8,205	1149	1756	2761	1557	982	3.1
Delta Dental	593	73	103	159	174	84	2.8
Premier Access	179	10	19	49	59	42	2.4
SafeGuard Dental	2,478	150	226	615	853	634	2.4
Access Dental	3,156	148	280	727	1132	869	2.3
Western Dental	666	32	67	118	213	236	2.2
Total	**15,277**	**1,562**	**2,451**	**4,429**	**3,988**	**2,847**	2.5

Survey Question	Number of Families Responding	Extremely Satisfied (5)	Very Satisfied (4)	Satisfied (3)	Not Very Satisfied (2)	Not at all (1)	Average Score
Question 3 *"How satisfied are you with the level of service you have received from your Vision Plan?"*							
Vision Service Plan	1832	263	382	844	249	94	3.3
Eye MED Vision Care	80	8	13	37	14	8	3.0
SafeGuard Vision	116	9	20	48	22	17	2.8
Total	**2028**	**280**	**415**	**929**	**285**	**119**	3.0

Open Enrollment 2006

Reasons Why Subscribers Changed Health Plans

NOTE: Responses are from families who voluntarily changed plans. Families can check more than one response.

Health Plan the Family Transferred Out Of:	Alameda Alliance for Health	Blue Cross EPO	Blue Cross HMO	Blue Shield EPO	Blue Shield HMO	CalOptima	Care1st Health Plan	Central Coast Alliance for Health	Community Health Group	Community Health Plan	Contra Costa Health Plan	Health Net Life EPO	Health Net HMO	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kaiser Permanente	Kern Family Health Care	L.A. CARE HEALTH PLN	Molina Healthcare	San Francisco Health Plan	Santa Barbara Regional Health Authority	Santa Clara Family Health Plan	Universal Care	Ventura County Health Care Plan	Total
Problem getting a doctor I'm happy with	42	164	763	11	374	103	77	12	69	225	26	5	442	20	21	188	119	53	29	342	6	9	39	-	22	3,161
	0.14%	0.56%	2.60%	0.04%	1.27%	0.35%	0.26%	0.04%	0.23%	0.77%	0.09%	0.02%	1.50%	0.07%	0.07%	0.64%	0.40%	0.18%	0.10%	1.16%	0.02%	0.03%	0.13%	0.00%	0.07%	10.75%
Appointments to see the doctor have to be made too long in advance. Check one:	38	141	607	5	320	123	67	9	69	264	23	3	392	16	24	161	125	51	26	340	10	8	43	-	22	2,867
	0.13%	0.48%	2.07%	0.02%	1.09%	0.42%	0.23%	0.03%	0.23%	0.90%	0.08%	0.01%	1.33%	0.05%	0.08%	0.55%	0.43%	0.17%	0.09%	1.16%	0.03%	0.03%	0.15%	0.00%	0.07%	9.82%
Two weeks	11	49	244	2	128	51	23	1	18	113	8	-	143	4	4	62	34	11	12	112	4	2	16	-	7	1,059
	0.04%	0.17%	0.83%	0.01%	0.44%	0.17%	0.08%	0.00%	0.06%	0.38%	0.03%	0.00%	0.49%	0.01%	0.01%	0.21%	0.12%	0.04%	0.04%	0.38%	0.01%	0.01%	0.05%	0.00%	0.02%	3.60%
Three weeks	8	52	150	1	106	39	23	6	23	72	5	2	94	6	6	53	41	11	6	87	1	1	10	-	4	807
	0.03%	0.18%	0.51%	0.00%	0.36%	0.13%	0.08%	0.02%	0.08%	0.24%	0.02%	0.01%	0.32%	0.02%	0.02%	0.18%	0.14%	0.04%	0.02%	0.30%	0.00%	0.00%	0.03%	0.00%	0.01%	2.75%
Four weeks or more	19	40	213	2	86	33	21	2	28	79	10	1	155	6	14	46	50	29	8	141	5	5	17	-	11	1,021
	0.06%	0.14%	0.73%	0.01%	0.29%	0.11%	0.07%	0.01%	0.10%	0.27%	0.03%	0.00%	0.53%	0.02%	0.05%	0.16%	0.17%	0.10%	0.03%	0.48%	0.02%	0.02%	0.06%	0.00%	0.04%	3.47%
Not being able to see a doctor when the need is urgent	35	114	534	6	247	107	52	6	59	172	25	4	335	13	15	133	94	47	19	256	4	6	38	-	21	2,342
	0.12%	0.39%	1.82%	0.02%	0.84%	0.36%	0.18%	0.02%	0.20%	0.59%	0.09%	0.01%	1.14%	0.04%	0.05%	0.45%	0.32%	0.16%	0.06%	0.87%	0.01%	0.02%	0.13%	0.00%	0.07%	7.97%
Not satisfied with medical care received	32	107	538	7	236	87	63	6	51	167	16	5	279	17	16	128	85	40	25	270	3	7	32	-	14	2,231
	0.11%	0.36%	1.83%	0.02%	0.80%	0.30%	0.21%	0.02%	0.17%	0.57%	0.05%	0.02%	0.95%	0.06%	0.05%	0.44%	0.29%	0.14%	0.09%	0.92%	0.01%	0.02%	0.11%	0.00%	0.05%	7.59%
Problem getting a specialist when I needed one	36	97	445	4	227	106	54	7	61	172	16	2	296	15	16	118	75	37	15	260	3	9	30	-	13	2,114
	0.12%	0.33%	1.51%	0.01%	0.77%	0.36%	0.18%	0.02%	0.21%	0.59%	0.05%	0.01%	1.01%	0.05%	0.05%	0.40%	0.26%	0.13%	0.05%	0.88%	0.01%	0.03%	0.10%	0.00%	0.04%	7.19%
Doctor's office is too far away. Check One:	21	119	406	3	186	91	48	4	36	180	13	3	287	13	9	102	110	25	16	198	6	2	26	-	7	1,911
	0.07%	0.40%	1.38%	0.01%	0.63%	0.31%	0.16%	0.01%	0.12%	0.61%	0.04%	0.01%	0.98%	0.04%	0.03%	0.35%	0.37%	0.09%	0.05%	0.67%	0.02%	0.01%	0.09%	0.00%	0.02%	6.50%
1-5 miles	10	41	141	-	66	35	20	2	13	100	7	-	103	9	4	37	18	9	8	84	2	1	10	-	2	722
	0.03%	0.14%	0.48%	0.00%	0.22%	0.12%	0.07%	0.01%	0.04%	0.34%	0.02%	0.00%	0.35%	0.03%	0.01%	0.12%	0.06%	0.03%	0.03%	0.29%	0.01%	0.00%	0.03%	0.00%	0.01%	2.46%
6-10 miles	4	35	134	2	54	26	19	2	12	41	1	2	81	2	5	33	34	6	7	41	3	-	7	-	2	553
	0.01%	0.12%	0.46%	0.01%	0.18%	0.09%	0.06%	0.01%	0.04%	0.14%	0.00%	0.01%	0.28%	0.01%	0.02%	0.11%	0.12%	0.02%	0.02%	0.14%	0.01%	0.00%	0.02%	0.00%	0.01%	1.88%
10 miles or more	7	43	131	1	66	30	9	-	11	39	5	1	103	2	-	32	58	10	1	73	1	1	9	-	3	636
	0.03%	0.15%	0.45%	0.00%	0.23%	0.10%	0.03%	0.00%	0.04%	0.13%	0.02%	0.00%	0.35%	0.01%	0.00%	0.11%	0.20%	0.03%	0.00%	0.25%	0.00%	0.00%	0.03%	0.00%	0.01%	2.16%
Not satisfied with the hours or days a primary care doctor's office is open	24	92	428	4	172	65	42	5	39	133	16	-	249	10	14	89	48	30	14	196	5	4	30	-	5	1,714
	0.08%	0.31%	1.46%	0.01%	0.59%	0.22%	0.14%	0.02%	0.13%	0.45%	0.05%	0.00%	0.85%	0.03%	0.05%	0.30%	0.16%	0.10%	0.05%	0.67%	0.02%	0.01%	0.10%	0.00%	0.02%	5.83%
Problem getting care that I or my doctor believed to be necessary	24	81	369	9	189	75	40	4	47	127	12	3	226	11	13	93	74	24	15	218	4	9	22	-	9	1,698
	0.08%	0.28%	1.26%	0.03%	0.64%	0.26%	0.14%	0.01%	0.16%	0.43%	0.04%	0.01%	0.77%	0.04%	0.04%	0.32%	0.25%	0.08%	0.05%	0.74%	0.01%	0.03%	0.07%	0.00%	0.03%	5.78%
Problem getting help or advice during regular office hours	26	77	384	4	162	62	32	4	52	123	17	-	221	12	9	90	61	30	15	186	3	6	34	-	7	1,617
	0.09%	0.26%	1.31%	0.01%	0.55%	0.21%	0.11%	0.01%	0.18%	0.42%	0.06%	0.00%	0.75%	0.04%	0.03%	0.31%	0.21%	0.10%	0.05%	0.63%	0.01%	0.02%	0.12%	0.00%	0.02%	5.50%
I do not like the condition of the doctor's office	12	63	364	1	150	47	40	2	23	110	9	1	172	12	7	87	24	29	13	158	5	1	19	-	5	1,354
	0.04%	0.21%	1.24%	0.00%	0.51%	0.16%	0.14%	0.01%	0.08%	0.37%	0.03%	0.00%	0.59%	0.04%	0.02%	0.30%	0.08%	0.10%	0.04%	0.54%	0.02%	0.00%	0.06%	0.00%	0.02%	4.61%
It took too long to receive laboratory results and diagnosis:	12	64	247	1	120	60	35	4	26	147	7	1	146	10	4	70	39	22	14	125	3	1	19	-	3	1,180
	0.04%	0.22%	0.84%	0.00%	0.41%	0.20%	0.12%	0.01%	0.09%	0.50%	0.02%	0.00%	0.50%	0.03%	0.01%	0.24%	0.13%	0.07%	0.05%	0.43%	0.01%	0.00%	0.06%	0.00%	0.01%	4.01%
Two weeks	6	32	118	1	60	32	18	2	12	89	4	-	66	7	2	31	18	8	9	56	3	-	10	-	1	585
	0.02%	0.11%	0.40%	0.00%	0.20%	0.11%	0.06%	0.01%	0.04%	0.30%	0.01%	0.00%	0.22%	0.02%	0.01%	0.11%	0.06%	0.03%	0.03%	0.19%	0.01%	0.00%	0.03%	0.00%	0.00%	1.99%
Three weeks	4	10	57	-	33	12	9	2	8	31	1	1	32	1	2	18	5	6	4	25	-	1	2	-	1	265
	0.01%	0.02%	0.19%	0.00%	0.11%	0.04%	0.02%	0.01%	0.03%	0.11%	0.00%	0.00%	0.11%	0.00%	0.01%	0.06%	0.02%	0.02%	0.01%	0.09%	0.00%	0.00%	0.01%	0.00%	0.00%	0.90%
Four weeks or more	2	22	72	-	27	16	8	-	6	27	2	-	48	2	-	21	16	8	1	44	-	-	7	-	1	330
	0.01%	0.07%	0.24%	0.00%	0.09%	0.05%	0.03%	0.00%	0.02%	0.09%	0.01%	0.00%	0.16%	0.01%	0.00%	0.07%	0.05%	0.03%	0.00%	0.15%	0.00%	0.00%	0.02%	0.00%	0.00%	1.12%
Primary care doctor left the plan	17	33	218	6	209	34	14	5	13	92	8	3	152	7	2	33	20	16	9	137	1	-	11	-	3	1,043
	0.06%	0.11%	0.74%	0.02%	0.71%	0.12%	0.05%	0.02%	0.04%	0.31%	0.03%	0.01%	0.52%	0.02%	0.01%	0.11%	0.07%	0.05%	0.03%	0.47%	0.00%	0.00%	0.04%	0.00%	0.01%	3.55%
Not satisfied with the hospital network available	14	39	208	2	107	31	21	4	26	80	3	4	115	3	10	72	45	15	7	106	2	3	12	-	8	937
	0.05%	0.13%	0.71%	0.01%	0.36%	0.11%	0.07%	0.01%	0.09%	0.27%	0.01%	0.01%	0.39%	0.01%	0.03%	0.24%	0.15%	0.05%	0.02%	0.36%	0.01%	0.01%	0.04%	0.00%	0.03%	3.19%
I did not agree with the course of treatment	6	34	184	1	89	42	18	2	19	71	5	1	109	7	2	47	45	14	6	96	2	1	15	-	4	820
	0.02%	0.12%	0.63%	0.00%	0.30%	0.14%	0.06%	0.01%	0.06%	0.24%	0.02%	0.00%	0.37%	0.02%	0.01%	0.16%	0.15%	0.05%	0.02%	0.33%	0.01%	0.00%	0.05%	0.00%	0.01%	2.79%
Not satisfied with customer service at the plan level	8	22	177	4	99	30	17	2	25	65	6	2	110	6	4	44	28	13	7	125	1	2	11	-	2	810
	0.03%	0.07%	0.60%	0.01%	0.34%	0.10%	0.06%	0.01%	0.09%	0.22%	0.02%	0.01%	0.37%	0.02%	0.01%	0.15%	0.10%	0.04%	0.02%	0.43%	0.00%	0.01%	0.04%	0.00%	0.01%	2.76%
Medication not covered by the plan	9	44	136	2	80	31	18	4	19	75	3	1	117	3	2	37	20	11	8	171	1	2	8	-	6	808
	0.03%	0.15%	0.46%	0.01%	0.27%	0.11%	0.06%	0.01%	0.06%	0.26%	0.01%	0.00%	0.40%	0.01%	0.01%	0.13%	0.07%	0.04%	0.03%	0.58%	0.00%	0.01%	0.03%	0.00%	0.02%	2.75%
Authorization for a medical treatment was denied	1	17	87	1	61	25	20	2	19	48	1	3	75	3	1	25	19	9	2	88	-	3	7	-	3	520
	0.00%	0.06%	0.30%	0.00%	0.21%	0.09%	0.07%	0.01%	0.06%	0.16%	0.00%	0.01%	0.26%	0.01%	0.00%	0.09%	0.06%	0.03%	0.01%	0.30%	0.00%	0.01%	0.02%	0.00%	0.01%	1.77%
Children are discriminated against because they are enrolled in Healthy Families	2	20	101	2	53	34	7	1	9	29	4	1	60	2	2	23	10	7	3	46	2	3	6	-	2	429
	0.01%	0.07%	0.34%	0.01%	0.18%	0.12%	0.02%	0.00%	0.03%	0.10%	0.01%	0.00%	0.20%	0.01%	0.01%	0.08%	0.03%	0.02%	0.01%	0.16%	0.01%	0.01%	0.02%	0.00%	0.01%	1.46%
I need an interpreter but doctor's office does not have one	2	26	73	1	33	13	14	1	14	46	6	-	61	4	-	14	25	8	4	39	3	-	9	-	1	397
	0.01%	0.09%	0.25%	0.00%	0.11%	0.04%	0.05%	0.00%	0.05%	0.16%	0.02%	0.00%	0.21%	0.01%	0.00%	0.05%	0.09%	0.03%	0.01%	0.13%	0.01%	0.00%	0.03%	0.00%	0.00%	1.35%
Optional Health benefits not available	1	12	55	2	26	12	7	1	11	28	-	2	40	3	3	6	12	2	3	29	-	1	4	-	1	261
	0.00%	0.04%	0.19%	0.01%	0.09%	0.04%	0.02%	0.00%	0.04%	0.10%	0.00%	0.01%	0.14%	0.01%	0.01%	0.02%	0.04%	0.01%	0.01%	0.10%	0.00%	0.00%	0.01%	0.00%	0.00%	0.89%
Other (write in):	12	48	298	14	161	30	16	3	32	75	5	4	157	5	8	61	29	21	6	150	2	5	8	-	10	1,160
	0.04%	0.16%	1.01%	0.05%	0.55%	0.10%	0.05%	0.01%	0.11%	0.26%	0.02%	0.01%	0.53%	0.02%	0.03%	0.21%	0.10%	0.07%	0.02%	0.51%	0.01%	0.02%	0.03%	0.00%	0.03%	3.95%
Total	**374**	**1,414**	**6,622**	**90**	**3,301**	**1,208**	**702**	**88**	**719**	**2,429**	**221**	**48**	**4,041**	**192**	**182**	**1,621**	**1,107**	**504**	**256**	**3,536**	**66**	**82**	**423**	**-**	**168**	**29,394**
	1.27%	**4.81%**	**22.53%**	**0.31%**	**11.23%**	**4.11%**	**2.39%**	**0.30%**	**2.45%**	**8.26%**	**0.75%**	**0.16%**	**13.75%**	**0.65%**	**0.62%**	**5.51%**	**3.77%**	**1.71%**	**0.87%**	**12.03%**	**0.22%**	**0.28%**	**1.44%**	**0.00%**	**0.57%**	**100.00%**

Open Enrollment 2006

Reasons Why Subscribers Changed Health Plans

NOTE: Responses are from families who voluntarily changed plans and those families who were required to change plans. Families can check more than one response.

Health Plan the Family Transferred Out Of:	Alameda Alliance for Health	Blue Cross EPO	Blue Cross HMO	Blue Shield EPO	Blue Shield HMO	CalOptima	CareFirst Health Plan	Central Coast Alliance for Health	Community Health Group	Community Health Plan	Contra Costa Health Plan	Health Net Life EPO	Health Net HMO	Health Plan of San Joaquin	Health Plan of San Mateo	Inland Empire Health Plan	Kaiser Permanente	Kern Family Health Care	L.A. CARE HEALTH PLN	Molina Healthcare	San Francisco Health Plan	Santa Barbara Regional Health Authority	Santa Clara Family Health Plan	Universal Care	Ventura County Health Care Plan	Total
Problem getting a doctor I'm happy with	43	186	768	12	374	104	77	12	70	226	26	5	458	21	22	191	120	53	29	342	7	9	39	211	22	**3,427**
	0.13%	0.57%	2.37%	0.04%	1.15%	0.32%	0.24%	0.04%	0.22%	0.70%	0.08%	0.02%	1.41%	0.06%	0.07%	0.59%	0.37%	0.16%	0.09%	1.05%	0.02%	0.03%	0.12%	0.65%	0.07%	10.56%
Appointments to see the doctor have to be made too long in advance. Check one:	39	163	614	5	322	125	67	9	70	264	23	3	412	17	25	166	126	51	26	341	10	8	43	373	23	**3,325**
	0.12%	0.50%	1.89%	0.02%	0.99%	0.39%	0.21%	0.03%	0.22%	0.81%	0.07%	0.01%	1.27%	0.05%	0.08%	0.51%	0.39%	0.16%	0.08%	1.05%	0.03%	0.02%	0.13%	1.15%	0.07%	10.24%
Two weeks	12	59	247	2	130	53	23	1	18	113	8	-	156	4	4	62	35	11	12	112	4	2	16	177	8	**1,269**
	0.04%	0.18%	0.76%	0.01%	0.40%	0.16%	0.07%	0.00%	0.06%	0.35%	0.02%	0.00%	0.48%	0.01%	0.01%	0.19%	0.11%	0.03%	0.04%	0.35%	0.01%	0.01%	0.05%	0.55%	0.02%	3.91%
Three weeks	8	57	151	1	106	39	23	6	23	72	5	2	99	6	7	57	41	11	6	87	1	1	10	87	4	**910**
	0.02%	0.18%	0.47%	0.00%	0.33%	0.12%	0.07%	0.02%	0.07%	0.22%	0.02%	0.01%	0.30%	0.02%	0.02%	0.18%	0.13%	0.03%	0.02%	0.27%	0.00%	0.00%	0.03%	0.27%	0.01%	2.80%
Four weeks or more	19	47	216	2	86	33	21	2	29	79	10	1	157	7	14	47	50	29	8	142	5	5	17	109	11	**1,146**
	0.06%	0.14%	0.67%	0.01%	0.26%	0.10%	0.06%	0.01%	0.09%	0.24%	0.03%	0.00%	0.48%	0.02%	0.04%	0.14%	0.15%	0.09%	0.02%	0.44%	0.02%	0.02%	0.05%	0.34%	0.03%	3.53%
Not being able to see a doctor when the need is urgent	36	125	537	6	250	107	52	6	60	173	25	4	343	13	16	137	94	47	19	256	5	6	38	130	21	**2,506**
	0.11%	0.39%	1.65%	0.02%	0.77%	0.33%	0.16%	0.02%	0.18%	0.53%	0.08%	0.01%	1.06%	0.04%	0.05%	0.42%	0.29%	0.14%	0.06%	0.79%	0.02%	0.02%	0.12%	0.40%	0.06%	7.72%
Not satisfied with medical care received	33	113	538	7	236	87	63	6	51	169	16	5	290	18	17	129	86	40	25	270	3	7	32	104	14	**2,359**
	0.10%	0.35%	1.66%	0.02%	0.73%	0.27%	0.19%	0.02%	0.16%	0.52%	0.05%	0.02%	0.89%	0.06%	0.05%	0.40%	0.26%	0.12%	0.08%	0.83%	0.01%	0.02%	0.10%	0.32%	0.04%	7.27%
Problem getting a specialist when I needed one	37	109	448	4	228	106	54	7	62	172	16	2	305	16	16	120	75	37	15	260	3	9	30	127	13	**2,271**
	0.11%	0.34%	1.38%	0.01%	0.70%	0.33%	0.17%	0.02%	0.19%	0.53%	0.05%	0.01%	0.94%	0.05%	0.05%	0.37%	0.23%	0.11%	0.05%	0.80%	0.01%	0.03%	0.09%	0.39%	0.04%	7.00%
Doctor's office is too far away. Check One:	23	139	415	3	188	95	49	4	37	181	13	3	304	15	9	109	110	25	16	199	6	2	26	284	7	**2,262**
	0.07%	0.43%	1.28%	0.01%	0.58%	0.29%	0.15%	0.01%	0.11%	0.56%	0.04%	0.01%	0.94%	0.05%	0.03%	0.34%	0.34%	0.08%	0.05%	0.61%	0.02%	0.01%	0.08%	0.87%	0.02%	6.97%
1-5 miles	11	50	145	-	66	36	20	2	14	100	7	-	111	10	4	38	18	9	8	84	2	1	10	155	2	**903**
	0.02%	0.15%	0.45%	0.00%	0.20%	0.11%	0.06%	0.01%	0.04%	0.31%	0.02%	0.00%	0.34%	0.03%	0.01%	0.12%	0.06%	0.03%	0.02%	0.26%	0.01%	0.00%	0.03%	0.48%	0.01%	2.78%
6-10 miles	4	36	136	2	55	27	20	2	12	41	1	2	85	2	5	33	34	6	7	41	3	-	7	69	2	**632**
	0.01%	0.11%	0.42%	0.01%	0.17%	0.08%	0.06%	0.01%	0.04%	0.12%	0.00%	0.01%	0.26%	0.01%	0.02%	0.10%	0.10%	0.02%	0.02%	0.13%	0.01%	0.00%	0.02%	0.21%	0.01%	1.95%
10 miles or more	8	53	134	1	67	32	9	-	11	40	5	1	108	3	-	38	58	10	1	74	1	1	9	60	3	**727**
	0.02%	0.16%	0.41%	0.00%	0.21%	0.10%	0.03%	0.00%	0.03%	0.12%	0.02%	0.00%	0.33%	0.01%	0.00%	0.12%	0.18%	0.03%	0.00%	0.23%	0.00%	0.00%	0.03%	0.18%	0.01%	2.24%
Not satisfied with the hours or days a primary care doctor's office is open	25	99	431	4	173	65	42	5	40	134	16	-	257	10	15	90	48	30	14	197	5	4	30	93	5	**1,832**
	0.08%	0.30%	1.33%	0.01%	0.53%	0.20%	0.13%	0.02%	0.12%	0.41%	0.05%	0.00%	0.79%	0.03%	0.05%	0.28%	0.15%	0.09%	0.04%	0.61%	0.02%	0.01%	0.09%	0.29%	0.02%	5.64%
Problem getting care that I or my doctor believed to be necessary	25	91	371	9	189	75	40	4	48	127	12	3	236	12	13	94	74	24	15	218	4	9	22	100	9	**1,824**
	0.08%	0.28%	1.14%	0.03%	0.58%	0.23%	0.12%	0.01%	0.15%	0.39%	0.04%	0.01%	0.73%	0.04%	0.04%	0.29%	0.23%	0.07%	0.05%	0.67%	0.01%	0.03%	0.07%	0.31%	0.03%	5.62%
Problem getting help or advice during regular office hours	27	84	386	4	163	62	32	4	53	123	17	-	228	12	10	91	61	30	15	186	3	6	34	80	8	**1,719**
	0.08%	0.26%	1.19%	0.01%	0.50%	0.19%	0.10%	0.01%	0.16%	0.38%	0.05%	0.00%	0.70%	0.04%	0.03%	0.28%	0.19%	0.09%	0.05%	0.57%	0.01%	0.02%	0.10%	0.25%	0.02%	5.30%
I do not like the condition of the doctor's office	13	68	365	1	151	47	40	2	23	111	9	1	179	12	7	88	25	29	13	158	5	1	19	70	5	**1,442**
	0.04%	0.21%	1.12%	0.00%	0.47%	0.14%	0.12%	0.01%	0.07%	0.34%	0.03%	0.00%	0.55%	0.04%	0.02%	0.27%	0.08%	0.09%	0.04%	0.49%	0.02%	0.00%	0.06%	0.22%	0.02%	4.44%
It took too long to receive laboratory results and diagnosis:	13	75	251	1	121	61	35	4	27	147	7	1	160	11	4	70	39	22	14	125	3	1	19	181	3	**1,395**
	0.04%	0.23%	0.77%	0.00%	0.37%	0.19%	0.11%	0.01%	0.08%	0.45%	0.02%	0.00%	0.49%	0.03%	0.01%	0.22%	0.12%	0.07%	0.04%	0.39%	0.01%	0.00%	0.06%	0.56%	0.01%	4.30%
Two weeks	6	42	119	1	61	33	18	2	12	89	4	-	74	8	2	31	18	8	9	56	3	-	10	117	1	**724**
	0.02%	0.13%	0.37%	0.00%	0.19%	0.10%	0.06%	0.01%	0.04%	0.27%	0.01%	0.00%	0.23%	0.02%	0.01%	0.10%	0.06%	0.02%	0.03%	0.17%	0.01%	0.00%	0.03%	0.36%	0.00%	2.23%
Three weeks	5	11	58	-	33	12	9	2	8	31	1	1	35	1	2	18	5	6	4	25	-	1	2	42	1	**313**
	0.02%	0.03%	0.18%	0.00%	0.10%	0.04%	0.03%	0.01%	0.02%	0.10%	0.00%	0.00%	0.11%	0.00%	0.01%	0.06%	0.02%	0.02%	0.01%	0.08%	0.00%	0.00%	0.01%	0.13%	0.00%	0.96%
Four weeks or more	2	22	74	-	27	16	8	-	7	27	2	-	51	2	-	21	16	8	1	44	-	-	7	22	1	**358**
	0.01%	0.07%	0.23%	0.00%	0.08%	0.05%	0.02%	0.00%	0.02%	0.08%	0.01%	0.00%	0.16%	0.01%	0.00%	0.06%	0.05%	0.02%	0.00%	0.14%	0.00%	0.00%	0.02%	0.07%	0.00%	1.10%
Primary care doctor left the plan	18	45	220	6	209	34	15	5	13	92	8	3	173	7	2	33	22	16	9	137	1	-	11	214	3	**1,296**
	0.06%	0.14%	0.68%	0.02%	0.64%	0.10%	0.05%	0.02%	0.04%	0.28%	0.02%	0.01%	0.53%	0.02%	0.01%	0.10%	0.07%	0.05%	0.03%	0.42%	0.00%	0.00%	0.03%	0.66%	0.01%	3.99%
Not satisfied with the hospital network available	15	44	210	2	107	31	21	4	26	80	3	4	125	3	10	74	46	15	7	106	2	3	12	62	8	**1,020**
	0.05%	0.14%	0.65%	0.01%	0.33%	0.10%	0.06%	0.01%	0.08%	0.25%	0.01%	0.01%	0.39%	0.01%	0.03%	0.23%	0.14%	0.05%	0.02%	0.33%	0.01%	0.01%	0.04%	0.19%	0.02%	3.14%
I did not agree with the course of treatment	8	35	184	1	89	42	18	2	19	71	5	1	113	7	2	48	46	14	6	96	2	1	15	52	4	**881**
	0.02%	0.11%	0.57%	0.00%	0.27%	0.13%	0.06%	0.01%	0.06%	0.22%	0.02%	0.00%	0.35%	0.02%	0.01%	0.15%	0.14%	0.04%	0.02%	0.30%	0.01%	0.00%	0.05%	0.16%	0.01%	2.71%
Medication not covered by the plan	10	51	136	2	80	31	18	4	19	75	3	1	125	3	3	39	20	11	8	171	1	2	8	53	6	**880**
	0.03%	0.16%	0.42%	0.01%	0.25%	0.10%	0.06%	0.01%	0.06%	0.23%	0.01%	0.00%	0.39%	0.01%	0.01%	0.12%	0.06%	0.03%	0.02%	0.53%	0.00%	0.01%	0.02%	0.16%	0.02%	2.71%
Not satisfied with customer service at the plan level	9	25	179	4	99	30	17	2	26	65	6	2	114	6	4	45	28	13	7	125	1	2	11	43	2	**865**
	0.03%	0.08%	0.55%	0.01%	0.30%	0.09%	0.05%	0.01%	0.08%	0.20%	0.02%	0.01%	0.35%	0.02%	0.01%	0.14%	0.09%	0.04%	0.02%	0.39%	0.00%	0.01%	0.03%	0.13%	0.01%	2.66%
Authorization for a medical treatment was denied	2	19	87	1	62	25	20	2	19	48	1	3	77	3	1	26	19	9	2	88	-	3	7	39	3	**566**
	0.01%	0.06%	0.27%	0.00%	0.19%	0.08%	0.06%	0.01%	0.06%	0.15%	0.00%	0.01%	0.24%	0.01%	0.00%	0.08%	0.06%	0.03%	0.01%	0.27%	0.00%	0.01%	0.02%	0.12%	0.01%	1.74%
Children are discriminated against because they are enrolled in Healthy Families	3	23	101	2	53	34	7	1	9	29	4	1	65	2	2	23	10	7	3	46	3	3	6	26	2	**465**
	0.01%	0.07%	0.31%	0.01%	0.16%	0.10%	0.02%	0.00%	0.03%	0.09%	0.01%	0.00%	0.20%	0.01%	0.01%	0.07%	0.03%	0.02%	0.01%	0.14%	0.01%	0.01%	0.02%	0.08%	0.01%	1.43%
I need an interpreter but doctor's office does not have one	3	29	73	1	35	13	14	2	15	46	6	-	65	4	-	16	25	8	4	39	3	-	9	46	1	**457**
	0.01%	0.09%	0.22%	0.00%	0.11%	0.04%	0.04%	0.01%	0.05%	0.14%	0.02%	0.00%	0.20%	0.01%	0.00%	0.05%	0.08%	0.02%	0.01%	0.12%	0.01%	0.00%	0.03%	0.14%	0.00%	1.41%
Optional Health benefits not available	2	15	55	2	26	12	7	1	11	28	-	2	44	3	3	6	12	2	3	29	-	1	4	25	1	**294**
	0.01%	0.05%	0.17%	0.01%	0.08%	0.04%	0.02%	0.00%	0.03%	0.09%	0.00%	0.01%	0.14%	0.01%	0.01%	0.02%	0.04%	0.01%	0.01%	0.09%	0.00%	0.00%	0.01%	0.08%	0.00%	0.91%
Other (write in):	12	96	302	14	163	33	16	3	32	77	5	4	202	5	8	63	31	22	6	152	2	5	9	104	11	**1,377**
	0.04%	0.30%	0.93%	0.04%	0.50%	0.10%	0.05%	0.01%	0.10%	0.24%	0.02%	0.01%	0.62%	0.02%	0.02%	0.19%	0.10%	0.07%	0.02%	0.47%	0.01%	0.02%	0.03%	0.32%	0.03%	4.24%
Total	**396**	**1,634**	**6,671**	**91**	**3,318**	**1,219**	**704**	**89**	**730**	**2,438**	**221**	**48**	**4,275**	**200**	**189**	**1,658**	**1,117**	**505**	**256**	**3,541**	**69**	**82**	**424**	**2,417**	**171**	**32,463**
	1.22%	**5.03%**	**20.55%**	**0.28%**	**10.22%**	**3.76%**	**2.17%**	**0.27%**	**2.25%**	**7.51%**	**0.68%**	**0.15%**	**13.17%**	**0.62%**	**0.58%**	**5.11%**	**3.44%**	**1.56%**	**0.79%**	**10.91%**	**0.21%**	**0.25%**	**1.31%**	**7.45%**	**0.53%**	**100.00%**

Open Enrollment 2006

Reasons Why Subscribers Changed Dental Plans

NOTE: Families can check more than one response.

Dental Plan the Family Transferred Out Of:	VOLUNTARY ONLY						VOLUNTARY AND REQUIRED						
	Access Dental	Delta Dental	Premier Access	SafeGuard Dental	Western Dental	Total	Access Dental	Delta Dental	Premier Access	SafeGuard Dental	Universal Care Dental	Western Dental	Total
Problem getting a Dentist I'm happy with	1,968	311	113	1,410	413	**4,215**	1,968	311	113	1,470	2,698	413	**6,973**
	3.45%	0.54%	0.20%	2.47%	0.72%	13.46%	3.45%	0.54%	0.20%	2.57%	4.72%	0.72%	12.21%
Appointments to see the dentist have to be made too long in advance. Check one:	1,668	183	65	1,186	263	**3,365**	1,669	183	65	1,245	3,297	263	**6,722**
	2.92%	0.32%	0.11%	2.08%	0.46%	10.75%	2.92%	0.32%	0.11%	2.18%	5.77%	0.46%	11.77%
Two weeks	205	33	9	156	56	**459**	205	33	9	164	498	56	**965**
	0.36%	0.06%	0.02%	0.27%	0.10%	1.47%	0.36%	0.06%	0.02%	0.29%	0.87%	0.10%	1.69%
Three weeks	314	41	9	273	64	**701**	314	41	9	287	675	64	**1,390**
	0.55%	0.07%	0.02%	0.48%	0.11%	2.24%	0.55%	0.07%	0.02%	0.50%	1.18%	0.11%	2.43%
Four weeks or more	-	109	47	757	143	**1,056**	1,150	109	47	794	2,124	143	**4,367**
	0.00%	0.19%	0.08%	1.33%	0.25%	3.37%	2.01%	0.19%	0.08%	1.39%	3.72%	0.25%	7.64%
Not satisfied with dental care received	1,592	171	68	1,184	351	**3,366**	1,592	171	68	1,218	2,066	351	**5,466**
	2.79%	0.30%	0.12%	2.07%	0.61%	10.75%	2.79%	0.30%	0.12%	2.13%	3.62%	0.61%	9.57%
Dentist's office is too far away. Check one:	1,155	137	39	660	249	**2,240**	1,155	137	39	712	2,075	249	**4,367**
	2.02%	0.24%	0.07%	1.16%	0.44%	7.15%	2.02%	0.24%	0.07%	1.25%	3.63%	0.44%	7.64%
1-5 miles	199	25	11	158	36	**429**	199	25	11	163	639	36	**1,073**
	0.35%	0.04%	0.02%	0.28%	0.06%	1.37%	0.35%	0.04%	0.02%	0.29%	1.12%	0.06%	1.88%
6-10 miles	361	31	5	215	77	**689**	361	31	5	224	632	77	**1,330**
	0.63%	0.05%	0.01%	0.38%	0.13%	2.20%	0.63%	0.05%	0.01%	0.39%	1.11%	0.13%	2.33%
10 miles or more	595	81	23	287	136	**1,122**	595	81	23	325	804	136	**1,964**
	1.04%	0.14%	0.04%	0.50%	0.24%	3.58%	1.04%	0.14%	0.04%	0.57%	1.41%	0.24%	3.44%
Not being able to see a dentist when the need is urgent	1,065	113	64	761	172	**2,175**	1,065	113	64	790	1,712	173	**3,917**
	1.86%	0.20%	0.11%	1.33%	0.30%	6.95%	1.86%	0.20%	0.11%	1.38%	3.00%	0.30%	6.86%
Problem getting care that I or my Dentist believed to be necessary	1,028	108	61	750	214	**2,161**	1,028	108	61	773	1,367	214	**3,551**
	1.80%	0.19%	0.11%	1.31%	0.37%	6.90%	1.80%	0.19%	0.11%	1.35%	2.39%	0.37%	6.22%
Primary care dentist left the plan	400	125	32	312	83	**952**	401	125	32	364	2,406	84	**3,412**
	0.70%	0.22%	0.06%	0.55%	0.15%	3.04%	0.70%	0.22%	0.06%	0.64%	4.21%	0.15%	5.97%
Problem getting a dental specialist when I need one	962	108	57	703	194	**2,024**	962	108	57	727	1,354	194	**3,402**
	1.68%	0.19%	0.10%	1.23%	0.34%	6.46%	1.68%	0.19%	0.10%	1.27%	2.37%	0.34%	5.96%
I do not like the condition of the dentist's office	766	85	26	615	190	**1,682**	766	85	26	629	1,141	190	**2,837**
	1.34%	0.15%	0.05%	1.08%	0.33%	5.37%	1.34%	0.15%	0.05%	1.10%	2.00%	0.33%	4.97%
Not satisfied with the hours or days a primary care dentist's office is open	761	68	15	590	122	**1,556**	761	68	15	605	1,254	122	**2,825**
	1.33%	0.12%	0.03%	1.03%	0.21%	4.97%	1.33%	0.12%	0.03%	1.06%	2.19%	0.21%	4.95%
Problem getting help or advice during regular office hours	606	50	19	448	121	**1,244**	606	50	19	456	939	121	**2,191**
	1.06%	0.09%	0.03%	0.78%	0.21%	3.97%	1.06%	0.09%	0.03%	0.80%	1.64%	0.21%	3.84%
I did not agree with the course of treatment	517	44	22	454	125	**1,162**	517	44	22	461	751	125	**1,920**
	0.91%	0.08%	0.04%	0.79%	0.22%	3.71%	0.91%	0.08%	0.04%	0.81%	1.31%	0.22%	3.36%
Not satisfied with customer service at the plan level	425	45	22	324	115	**931**	425	45	22	327	586	116	**1,521**
	0.74%	0.08%	0.04%	0.57%	0.20%	2.97%	0.74%	0.08%	0.04%	0.57%	1.03%	0.20%	2.66%
It took too long to receive laboratory results and diagnosis:	305	33	12	205	61	**616**	305	33	12	215	707	61	**1,333**
	0.53%	0.06%	0.02%	0.36%	0.11%	1.97%	0.53%	0.06%	0.02%	0.38%	1.24%	0.11%	2.33%
Two weeks	75	14	6	68	23	**186**	75	14	6	75	300	23	**493**
	0.13%	0.02%	0.01%	0.12%	0.04%	0.59%	0.13%	0.02%	0.01%	0.13%	0.53%	0.04%	0.86%
Three weeks	93	9	1	55	17	**175**	93	9	1	57	197	17	**374**
	0.16%	0.02%	0.00%	0.10%	0.03%	0.56%	0.16%	0.02%	0.00%	0.10%	0.34%	0.03%	0.65%
Four weeks or more	137	10	5	82	21	**255**	137	10	5	83	210	21	**466**
	0.24%	0.02%	0.01%	0.14%	0.04%	0.81%	0.24%	0.02%	0.01%	0.15%	0.37%	0.04%	0.82%
Children are discriminated against because they are enrolled in Healthy Families	328	63	27	278	64	**760**	328	63	27	290	469	64	**1,241**
	0.57%	0.11%	0.05%	0.49%	0.11%	2.43%	0.57%	0.11%	0.05%	0.51%	0.82%	0.11%	2.17%
Aurthorization for a dental treatment was denied	274	35	21	203	54	**587**	274	35	21	209	445	54	**1,039**
	0.48%	0.06%	0.04%	0.36%	0.09%	1.87%	0.48%	0.06%	0.04%	0.37%	0.78%	0.09%	1.82%
I need an interpreter but dentist's office does not have one	264	30	10	177	43	**524**	265	30	10	183	443	43	**974**
	0.46%	0.05%	0.02%	0.31%	0.08%	1.67%	0.46%	0.05%	0.02%	0.32%	0.77%	0.08%	1.71%
Medication not covered by the plan	183	24	10	163	35	**415**	183	24	10	168	342	35	**762**
	0.32%	0.04%	0.02%	0.29%	0.06%	1.33%	0.32%	0.04%	0.02%	0.29%	0.60%	0.06%	1.33%
Optional Dental benefits not available	10	4	2	5	5	**26**	10	4	2	5	14	5	**40**
	0.02%	0.01%	0.00%	0.01%	0.01%	0.08%	0.02%	0.01%	0.00%	0.01%	0.02%	0.01%	0.07%
Other (write in):	562	131	36	437	141	**1,307**	562	131	37	474	1,286	142	**2,632**
	0.98%	0.23%	0.06%	0.77%	0.25%	4.17%	0.98%	0.23%	0.06%	0.83%	2.25%	0.25%	4.61%
Total	**14,839**	**1,868**	**721**	**10,865**	**3,015**	**31,308**	**14,842**	**1,868**	**722**	**11,321**	**25,353**	**3,019**	**57,125**
	25.98%	**3.27%**	**1.26%**	**19.02%**	**5.28%**	**100.00%**	**25.98%**	**3.27%**	**1.26%**	**19.82%**	**44.38%**	**5.28%**	**100.00%**

Open Enrollment 2006

Reasons Why Subscribers Changed Vision Plans

NOTE: Families can check more than one response.

Vision Plan the Family Transferred Out Of:	VOLUNTARY ONLY				VOLUNTARY AND REQUIRED			
	Eye Med Vision Care	SafeGuard Vision	Vision Service Plan	Total	Eye Med Vision Care	SafeGuard Vision	Vision Service Plan	Total
Appointments to see the optometrist have to be made too long in advance. Check one:	13 0.45%	13 0.45%	403 13.85%	**429** 14.74%	13 0.45%	13 0.45%	403 13.85%	**429** 14.74%
Two weeks	- 0.00%	3 0.10%	131 4.50%	**134** 4.60%	2 0.07%	3 0.10%	131 4.50%	**136** 4.67%
Three weeks	5 0.17%	3 0.10%	101 3.47%	**109** 3.75%	5 0.17%	3 0.10%	101 3.47%	**109** 3.75%
Four weeks or more	6 0.21%	7 0.24%	171 5.88%	**184** 6.32%	6 0.21%	7 0.24%	171 5.88%	**184** 6.32%
Problem getting an optometrist I'm happy with	26 0.89%	40 1.37%	317 10.89%	**383** 13.16%	26 0.89%	41 1.41%	317 10.89%	**384** 13.20%
Optometrist's office is too far away. Check one:	16 0.55%	11 0.38%	305 10.48%	**332** 11.41%	16 0.55%	12 0.41%	305 10.48%	**333** 11.44%
1-5 miles	2 0.07%	4 0.14%	106 3.64%	**112** 3.85%	2 0.07%	4 0.14%	106 3.64%	**112** 3.85%
6-10 miles	4 0.14%	3 0.10%	93 3.20%	**100** 3.44%	4 0.14%	4 0.14%	93 3.20%	**101** 3.47%
10 miles or more	10 0.34%	4 0.14%	106 3.64%	**120** 4.12%	10 0.34%	4 0.14%	106 3.64%	**120** 4.12%
Not satisfied with vision care received	13 0.45%	14 0.48%	201 6.91%	**228** 7.84%	13 0.45%	14 0.48%	201 6.91%	**228** 7.84%
Problem getting care that I or my optometrist believed to be necessary	13 0.45%	14 0.48%	132 4.54%	**159** 5.46%	13 0.45%	14 0.48%	132 4.54%	**159** 5.46%
Not being able to see an optometrist when the need is urgent	10 0.34%	13 0.45%	134 4.60%	**157** 5.40%	10 0.34%	13 0.45%	134 4.60%	**157** 5.40%
Problem getting a vision specialist when I need one	8 0.27%	12 0.41%	133 4.57%	**153** 5.26%	8 0.27%	12 0.41%	133 4.57%	**153** 5.26%
Not satisfied with the hours or days a primary care optometrist's office is open	7 0.24%	10 0.34%	108 3.71%	**125** 4.30%	7 0.24%	10 0.34%	108 3.71%	**125** 4.30%
Primary care optometrist left the plan	4 0.14%	6 0.21%	107 3.68%	**117** 4.02%	4 0.14%	7 0.24%	107 3.68%	**118** 4.05%
It took too long to receive laboratory results and diagnosis:	5 0.17%	1 0.03%	107 3.68%	**113** 3.88%	5 0.17%	1 0.03%	107 3.68%	**113** 3.88%
Two weeks	2 0.07%	- 0.00%	55 1.89%	**57** 1.96%	2 0.07%	- 0.00%	55 1.89%	**57** 1.96%
Three weeks	1 0.03%	- 0.00%	26 0.89%	**27** 0.93%	1 0.03%	- 0.00%	26 0.89%	**27** 0.93%
Four weeks or more	2 0.07%	1 0.03%	26 0.89%	**29** 1.00%	2 0.07%	1 0.03%	26 0.89%	**29** 1.00%
Problem getting help or advice during regular office hours	6 0.21%	7 0.24%	85 2.92%	**98** 3.37%	6 0.21%	7 0.24%	85 2.92%	**98** 3.37%
I do not like the condition of the optometrist's office	7 0.24%	7 0.24%	77 2.65%	**91** 3.13%	7 0.24%	7 0.24%	77 2.65%	**91** 3.13%
I need an interpreter but the optometrist's office does not have one	5 0.17%	7 0.24%	70 2.41%	**82** 2.82%	5 0.17%	7 0.24%	70 2.41%	**82** 2.82%
Not satisfied with customer service at the plan level	6 0.21%	6 0.21%	62 2.13%	**74** 2.54%	6 0.21%	6 0.21%	62 2.13%	**74** 2.54%
Children are discriminated against because they are enrolled in Healthy Families	2 0.07%	3 0.10%	57 1.96%	**62** 2.13%	2 0.07%	3 0.10%	57 1.96%	**62** 2.13%
I did not agree with the course of treatment	- 0.00%	4 0.14%	55 1.89%	**59** 2.03%	- 0.00%	4 0.14%	55 1.89%	**59** 2.03%
Medication not covered by the plan	5 0.17%	2 0.07%	45 1.55%	**52** 1.79%	5 0.17%	2 0.07%	45 1.55%	**52** 1.79%
Aurthorization for a vision treatment was denied	- 0.00%	1 0.03%	39 1.34%	**40** 1.37%	- 0.00%	1 0.03%	39 1.34%	**40** 1.37%
Optional Vision benefits not available	1 0.03%	- 0.00%	1 0.03%	**2** 0.07%	1 0.03%	- 0.00%	1 0.03%	**2** 0.07%
Other (write in):	7 0.24%	10 0.34%	134 4.60%	**151** 5.19%	7 0.24%	10 0.34%	134 4.60%	**151** 5.19%
Total	**154** **5.29%**	**181** **6.22%**	**2,572** **88.38%**	**2,907** **100.00%**	**154** **5.29%**	**184** **6.32%**	**2,572** **88.38%**	**2,910** **100.00%**

ATTACHMENT II:

HEALTHY FAMILIES PROGRAM 2006 REPORT OF CONSUMER SURVEYS OF HEALTH PLANS

EXECUTIVE SUMMARY

This report summarizes results from the 2006 consumer satisfaction survey of health plans for the Healthy Families Program (HFP). The survey is an important tool in monitoring quality and access to services. Subscribers receive this information during the Open Enrollment period and in the Program handbook which gives them additional facts about their health plan choices.

The results from 2006 survey show that the Program has maintained the same level of satisfaction since the survey was done in 2003 with some plans showing improvements or declines in some of the measures as indicated on the following pages. The results also indicate that the Program's performance was comparable to other SCHIP and Medicaid programs. Funding was not allocated for this survey in 2004 and 2005.

SURVEY METHODOLOGY

MRMIB conducted the survey through an independent survey vendor, DataStat, Inc., using the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS®)[1] 3.0 questionnaire. The questionnaire contained 76 questions. Responses to the questions have been summarized into four global ratings and five composite scores. The global ratings included ratings of:

- health plan
- health care
- regular doctor or nurse
- specialist

The composite scores included ratings of:

- getting needed care
- getting care quickly
- how well doctors communicate
- courteous and helpful office staff
- customer service.

DataStat, Inc. conducted the survey over an 8-week period between August and October 2006. DataStat used a mixed mode (telephone and mail) five-step protocol. The five-step protocol consisted of:

- a pre-notification mailing
- an initial survey mailing

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

- a reminder postcard to all respondents
- a second survey mailing
- a second reminder postcard to all non-respondents.

Telephone follow-up was conducted for non-respondents in English and Spanish only. The CAHPS protocol for conducting the telephone follow-up in the Asian languages has not been developed. DataStat consulted with MRMIB staff to develop the pre-notification and follow-up letters based on recommended samples from the CAHPS® 3.0 protocol.

The survey was administered in five languages – English, Spanish, Chinese, Korean and Vietnamese. Families with a non-English language preference received two separate survey booklets – one in English and one in the written language selected on the HFP application.

Nine-hundred families per health plan were sampled for the survey. The sample size for these surveys was determined by the minimum number of returned surveys needed for the analysis and the expected response rates. MRMIB used the sample size recommended for commercial plan surveys because response rates for the HFP surveys have been comparable to commercial plan subscriber response rates.

Twenty-two plans had sufficient HFP enrollment to provide the target sample. Three plans did not have sufficient enrollment to provide the target sample. Subscribers in these plans who met the age and continuous enrollment criteria were surveyed. The number of families who were selected for the survey and the distribution of language surveys for each participating health plan are presented in Table 1.

Table 1 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Alameda Alliance for Health	900	265	407	202	2	24
Blue Cross - EPO	900	433	437	12	11	7
Blue Cross - HMO	900	423	366	56	38	17
Blue Shield - EPO	900	752	128	10	5	5
Blue Shield - HMO	900	488	285	62	39	26
CalOptima	900	133	620	4	22	121
Care 1st Health Plan	900	246	631	16	3	4
Central Coast Alliance for Health	900	258	632	5	1	4
Community Health Group	900	222	657	9	2	10
Community Health Plan	900	204	647	35	5	9
Contra Costa Health Plan	900	227	654	9	2	8
Health Net	900	453	364	58	7	18
Health Net Life	255	202	53	0	0	0
Health Plan of San Joaquin	900	372	497	23	0	8
Health Plan of San Mateo	900	242	643	13	0	2
Inland Empire Health Plan	900	365	524	3	2	6
Kaiser Permanente	900	521	355	15	3	6
Kern Family Health Care	900	357	541	1	0	1
LA Care	219	92	121	4	2	0
Molina	900	316	567	11	2	4
San Francisco Health Plan	900	169	151	572	0	8
Santa Barbara Regional Health Authority	741	194	545	1	0	1
Santa Clara Family Health Plan	900	187	505	24	1	183
Universal Care*	900	211	669	0	2	18
Ventura County Health Plan	900	211	687	0	1	1
Total	**21,015**	**7,543**	**11,686**	**1,145**	**150**	**491**

E= English S=Spanish C=Chinese K=Korean V=Vietnamese

** Universal Care is no longer participating in the Healthy Families Program, but was included in the 2006 survey.*

Table 1 shows that most of the surveys were distributed in English and Spanish. Chinese, Korean and Vietnamese surveys comprised nine percent (9%) of the total sample. However, the surveys for Alameda Alliance for Health Plan and San Francisco Health Plan comprise twenty-two percent (22%) and sixty-four percent (64%) of these languages respectively.

SURVEY RESULTS: OVERALL RATINGS

All plans had an adequate number of returned surveys to permit the analysis for plan-to-plan comparisons. The minimum number of responses needed for the analysis was 411 completed surveys per plan, which is the target number that NCQA defines for accreditation purposes. This goal allows for at least 100 responses per question for a comparative analysis and is comparable to most types of statistical testing. Tests are considered statistically significant when the number of cases used to compute each score is 30 or greater.

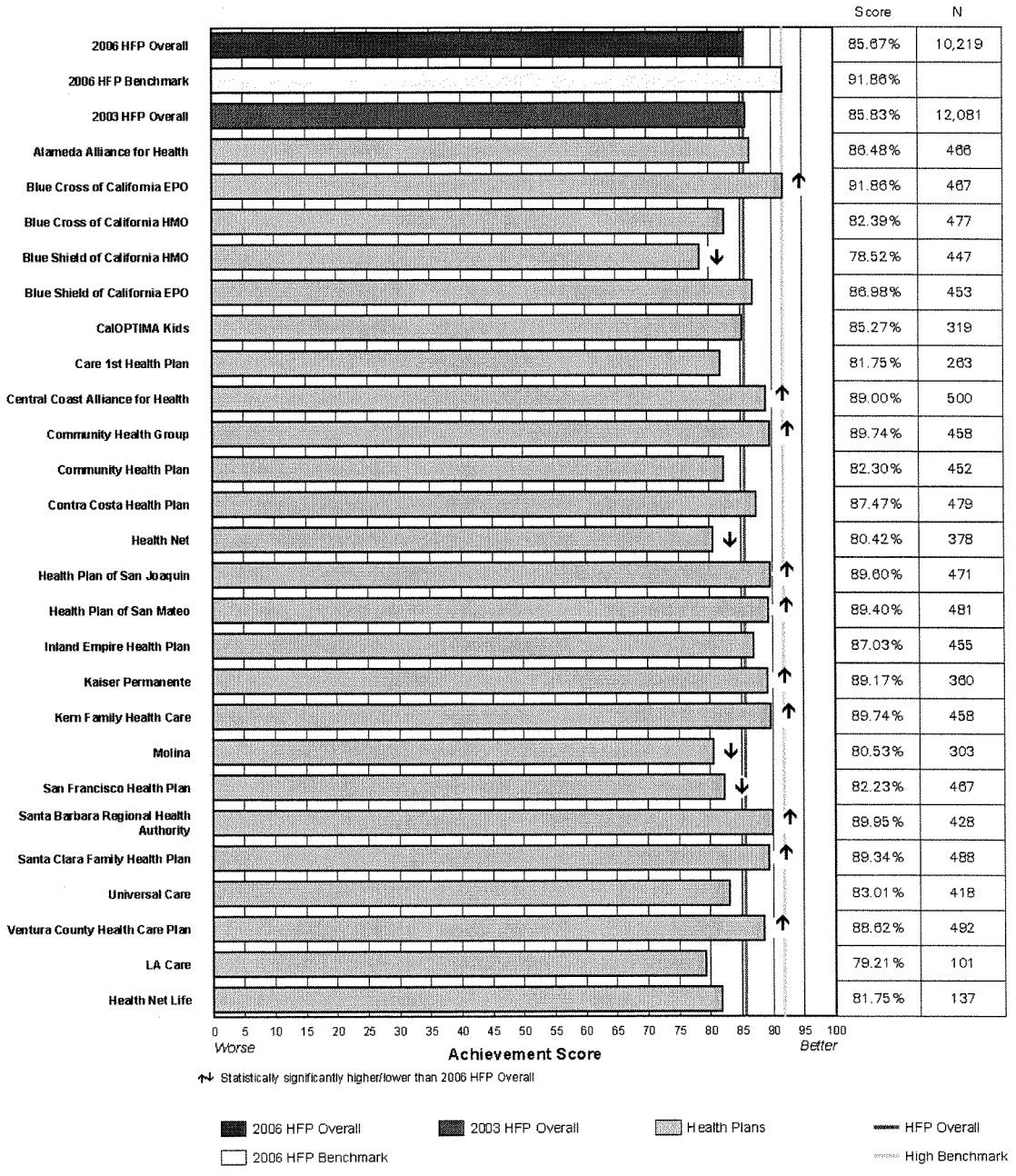
For the four rating questions, a 10-point scale was used to assess the overall experience with health plans, healthcare, providers and specialists. The scale uses "0" to represent the worst scores and "10" to represent the best score. The achievement scores for these

questions were determined by the percentage of families responding to each question using an 8, 9 or 10 rating. Individual plan scores for the 2006 survey are compared with the overall program score in 2006 and 2003 and a benchmark. This benchmark is based on the highest score achieved by a participating health plan with a minimum of 75 responses.

The following pages contain the HFP overall scores and the individual plan results for the overall rating questions. Plans that have achievement scores significantly higher or lower than the overall program score are indicated by a "↑" or "↓" next to their scores.

Overall Ratings (8, 9, 10)

Q62. Overall rating of health plan

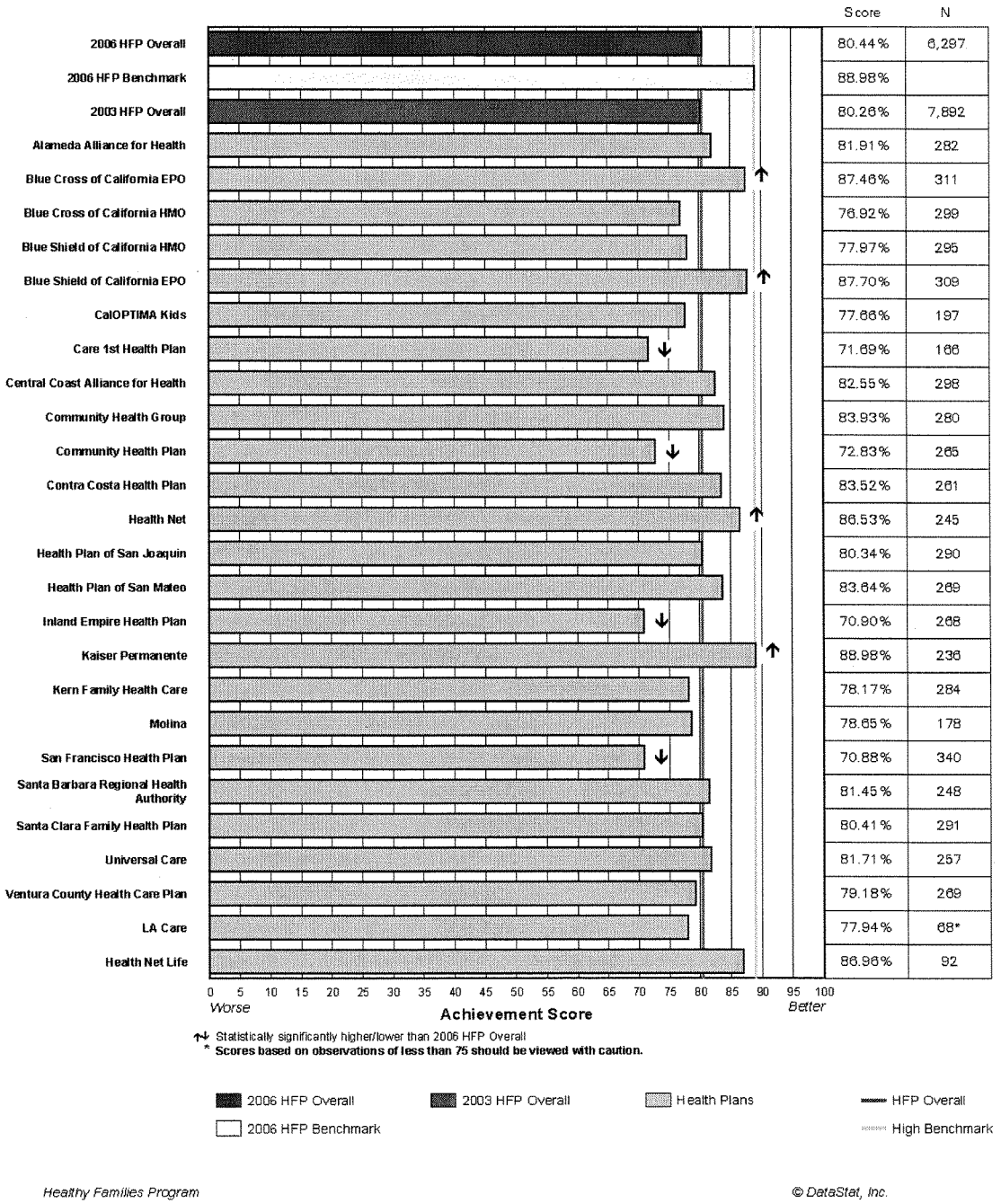


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Overall Ratings (8, 9, 10)

Q39. Overall rating of health care

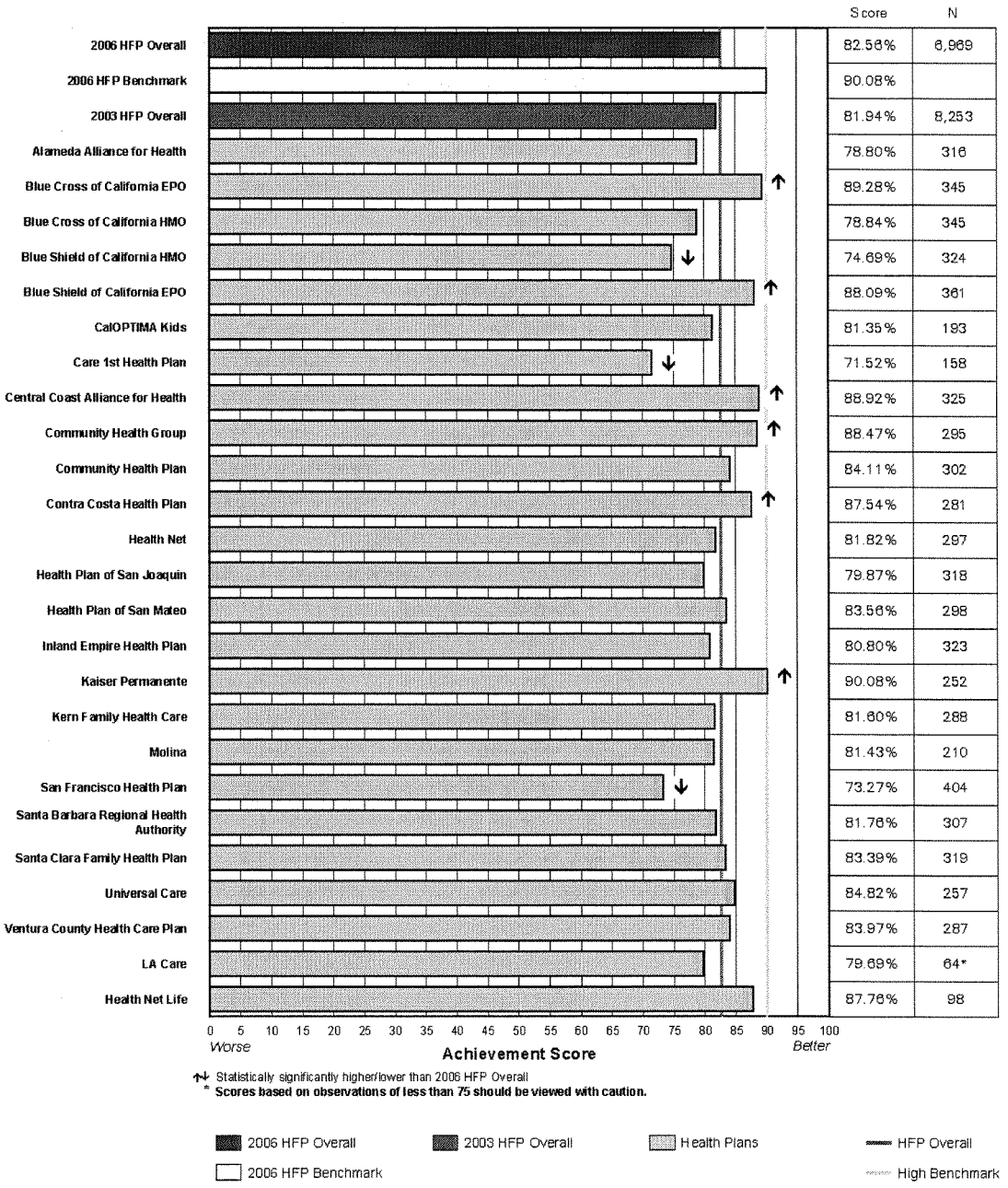


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Overall Ratings (8, 9, 10)

Q5. Overall rating of personal doctor or nurse

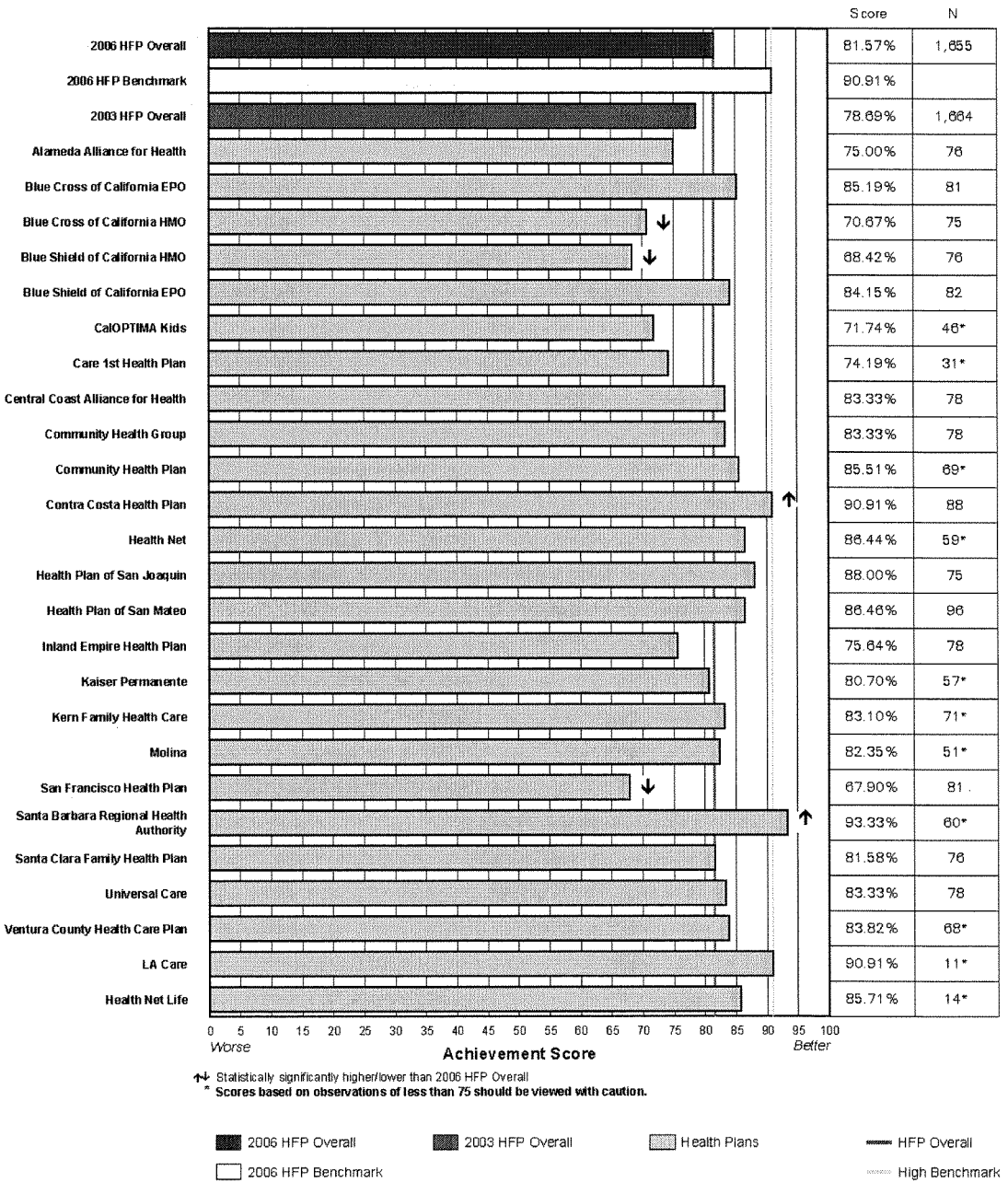


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Overall Ratings (8, 9, 10)

Q12. Overall rating of specialist



Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Summary of Rating Question Responses

The following changes occurred in the overall ratings from 2003 to 2006:

- The rating of *Specialist* increased from 2003 (78.7%) to 2006 (81.6%) and was a statistically significant improvement.
- The rating of *Personal Doctor or Nurse* improved slightly from 2003 (81.9%) to 2006 (82.6%), but it was not statistically significant.
- The rating of *Health Care* was about the same from 2003 (80.3%) to 2006 (80.4%).
- The rating of *Health Plan* was about the same from 2003 (85.8%) to 2006 (85.7%).

Table 2 shows whether the plan results for the ratings questions were statistically significantly above or below the program average score for 2006.

The following plans had achievement scores that were significantly above the program average in two or more questions:

- Blue Cross EPO and Kaiser Permanente achieved above average scores in three of the four questions.
- Blue Shield EPO, Central Coast Alliance for Health, Community Health Group and Contra Costa Health Plan achieved above average scores in two of the four questions.

The following plans had achievement scores that were significantly below the program average in two or more questions:

- Blue Shield HMO received below average scores in three of the four questions.
- Care 1st Health Plan received below average scores in two of the four questions.
- San Francisco Health Plan received below average scores in all four questions.

In 2000, an over sampling of families who received the survey in Chinese, Vietnamese and Korean showed that families responding in these languages rated the various factors less favorably than families responding in English and Spanish. These differences in responses among language groups may affect the scores of San Francisco Health Plan with a large number of subscribers whose primary language is one of the Asian languages. One area that MRMIB continues to explore is the differences in survey responses among the five language groups.

Table 2 – Statistically Significantly Higher and Lower than HFP Overall Ratings Scores

Health Plan	Overall Health Plan	Overall Health Care	Overall Personal Doctor or Nurse	Overall Specialist
Alameda Alliance for Health				
Blue Cross – EPO	▲	▲	▲	
Blue Cross – HMO				▼
Blue Shield – EPO		▲	▲	
Blue Shield – HMO	▼		▼	▼
CalOptima				
Care 1st Health Plan		▼	▼	
Central Coast Alliance for Health	▲		▲	
Community Health Group	▲		▲	
Community Health Plan		▼		
Contra Costa Health Plan			▲	▲
Health Net	▼	▲		
Health Net Life				
Health Plan of San Joaquin	▲			
Health Plan of San Mateo	▲			
Inland Empire Health Plan		▼		
Kaiser Permanente	▲	▲	▲	
Kern Family Health Care	▲			
LA Care				
Molina	▼			
San Francisco Health Plan	▼	▼	▼	▼
Santa Barbara Regional Health Authority	▲			▲
Santa Clara Family Health Plan	▲			
Universal Care*				
Ventura County Health Plan	▲			

**Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey*

▲ = Statistically significantly higher than HFP Overall Rating Scores

▼ = Statistically significantly lower than HFP Overall Rating Scores

Table 3 shows changes in plan scores that have increased or decreased 4 or more percentage points from 2003 to 2006.

Table 3 – Plan Performance Changes in Overall Ratings from 2003 to 2006

Health Plan	Overall Health Plan	Overall Health Care	Overall Personal Doctor or Nurse	Overall Specialist
Alameda Alliance for Health	↑ (4%)	↑ (4%)		
Blue Cross – EPO				
Blue Cross – HMO				
Blue Shield – EPO				↑ (14%)
Blue Shield – HMO			↓ (5%)	↓ (4%)
CalOptima				↓ (8%)
Care 1st Health Plan		↓ (6%)	↓ (7%)	↓ (5%)
Central Coast Alliance for Health				
Community Health Group	↑ (4%)		↑ (5%)	
Community Health Plan			↑ (10%)	↑ (17%)
Contra Costa Health Plan				↑ (9%)
Health Net		↑ (6%)		↑ (13%)
Health Net Life*				
Health Plan of San Joaquin		↓ (4%)		↑ (8%)
Health Plan of San Mateo		↑ (5%)		
Inland Empire Health Plan		↓ (10%)		↓ (22%)
Kaiser Permanente				
Kern Family Health Care				↑ (10%)
LA Care*				
Molina	↓ (7%)			
San Francisco Health Plan				↑ (10%)
Santa Barbara Regional Health Authority		↓ (6%)		↑ (5%)
Santa Clara Family Health Plan			↑ (5%)	
Universal Care**				
Ventura County Health Plan		↓ (5%)	↓ (4%)	

** Health Net Life and LA Care are new plans participating in the Healthy Families Program and no data is available for the 2003 survey for comparison*

*** Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.*

SURVEY RESULTS: COMPOSITE SCORES

The composite score is made up of questions that are grouped by related broad domains of performance. An example of this grouping, *Getting Care Quickly* includes questions about getting advice by phone, about how soon appointments were scheduled, and about time spent waiting in the doctor's office. The achievement score for each composite is determined by the percentage of families who respond positively to each question that comprises the composite. A response is considered positive if the answers are "not a problem" for the questions comprising the *Getting Needed Care* and *Customer Service* composites, and "usually" and "always" for the *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* composites.

The survey questions that comprise each composite score are listed below.

Getting Needed Care

- Able to get a personal doctor or nurse for child you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's health care while awaiting approval

Getting Care Quickly

- Usually or always got help or advice needed for child when calling during regular office hours
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for an illness/injury as soon as wanted
- Child never or sometimes waited more than 15 minutes to be taken to the exam room

How Well Doctor's Communicate

- Doctors usually or always listened carefully
- Doctors usually or always explained things in an understandable way
- Doctors usually or always showed respect
- Doctors usually or always spent enough time with child

Courteous and Helpful Office Staff

- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

Customer Service

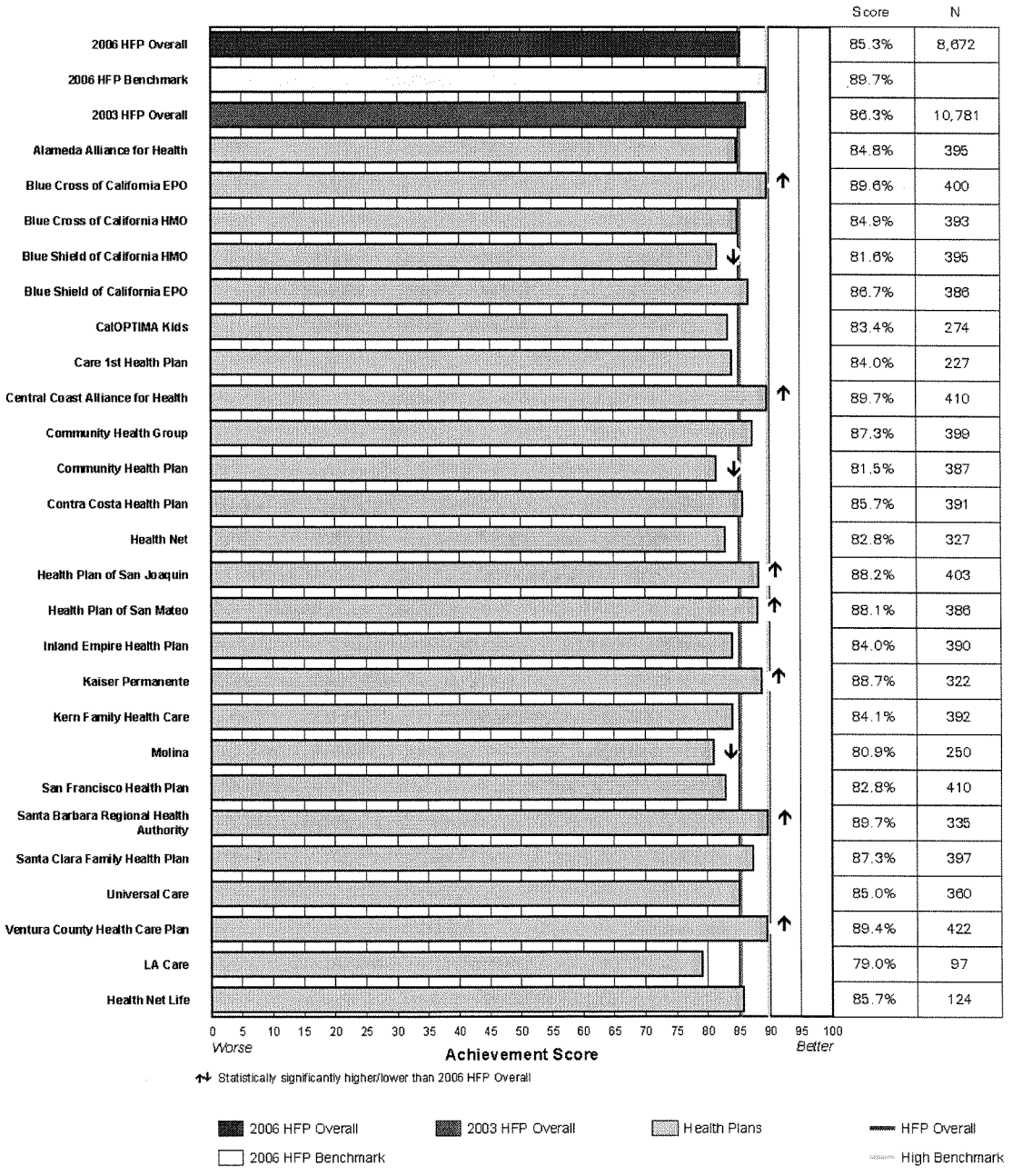
- Able to find or understand information in written materials
- Able to get help needed when you called child's health plan's customer service

Meaningful differences in the composite scores from one year to the next are more appropriately evaluated by examining changes in the scores of the individual questions that make up each composite score rather than testing for statistical significance.

The following pages contain the HFP overall program scores and the individual plan results for the composite scores. Plans that have achievement scores significantly higher or lower than the overall program score are indicated by a "↑" or "↓" next to their scores.

Getting Needed Care

Composite Score

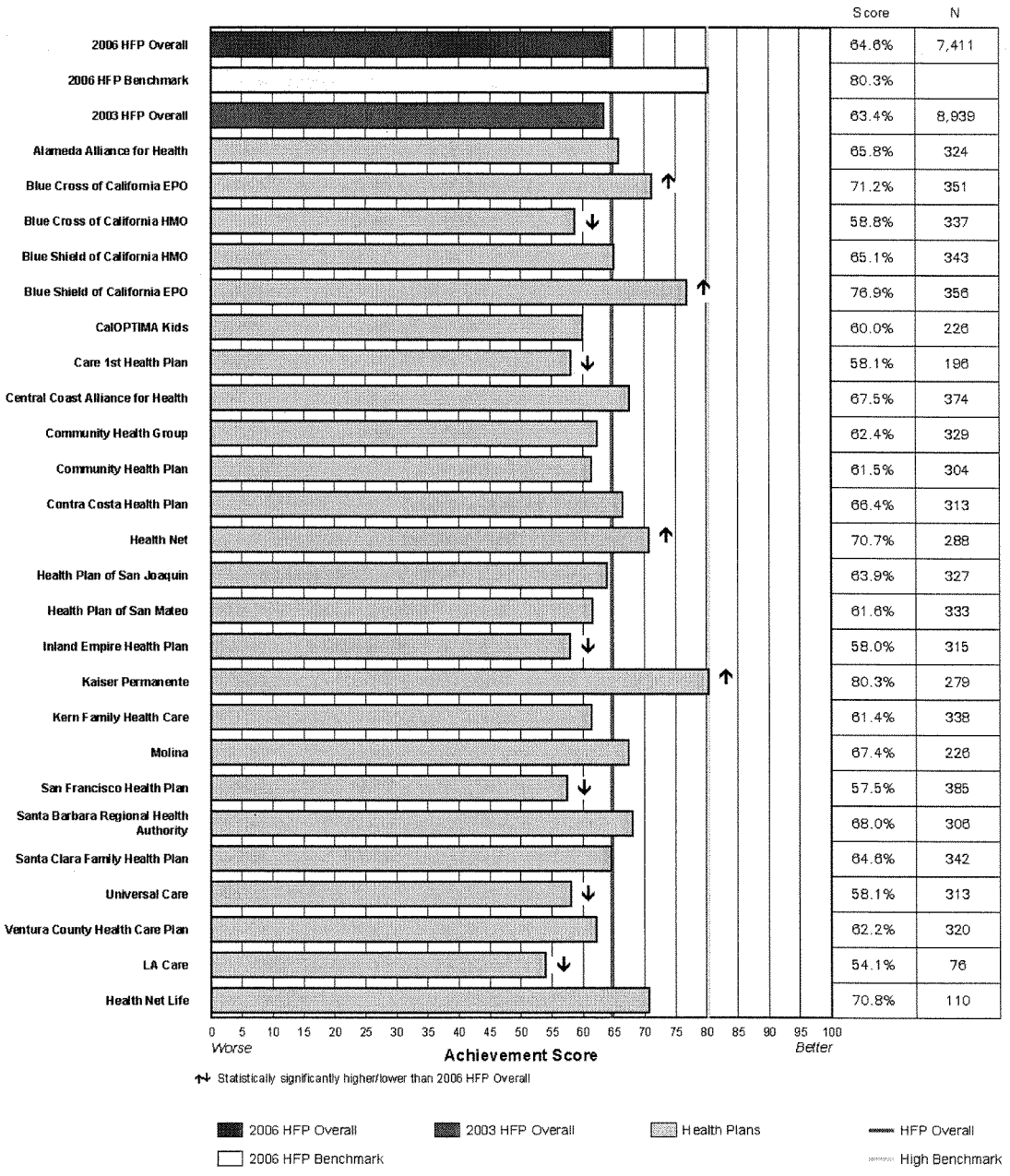


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.

Getting Care Quickly

Composite Score

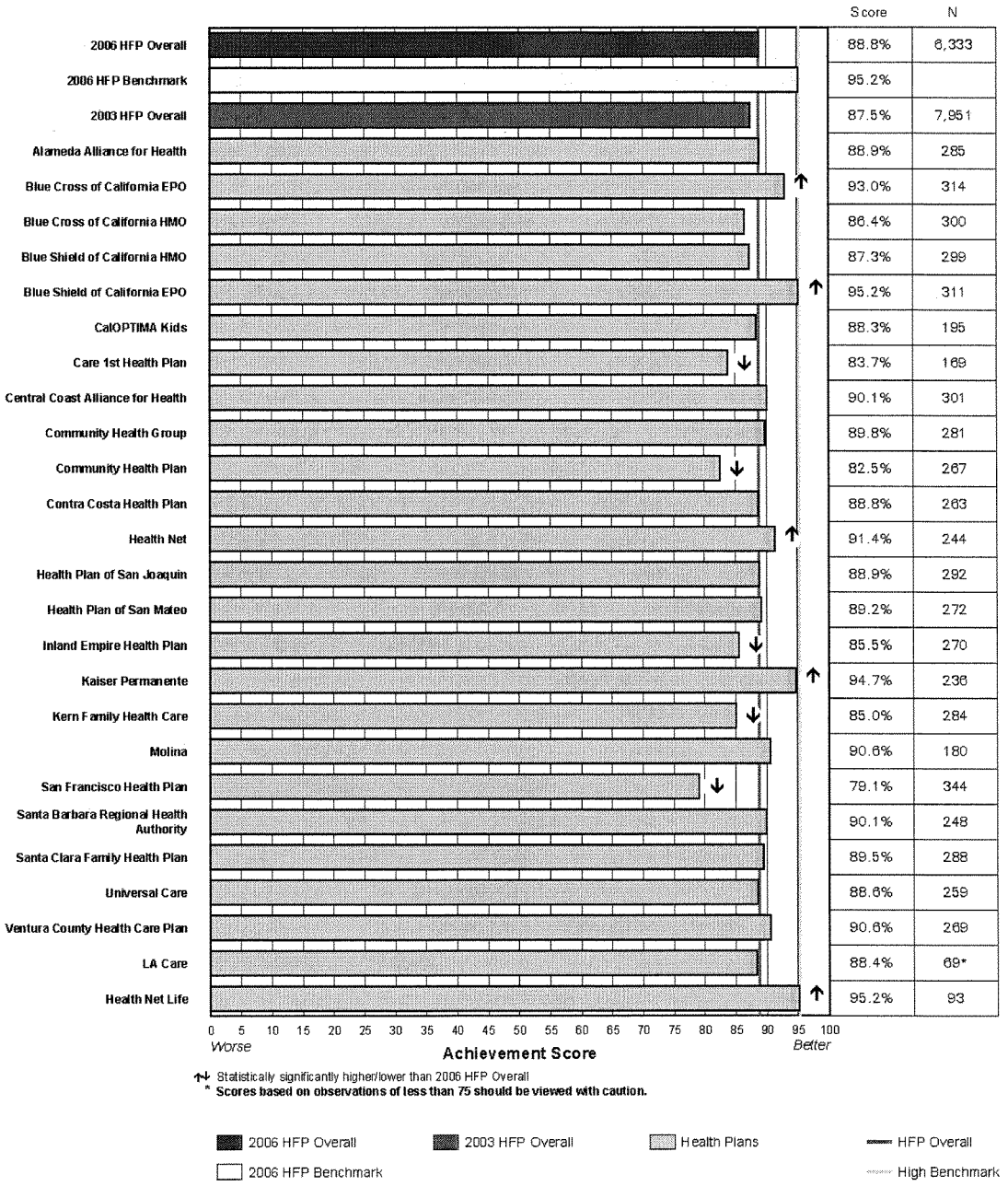


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.

How Well Doctors Communicate

Composite Score

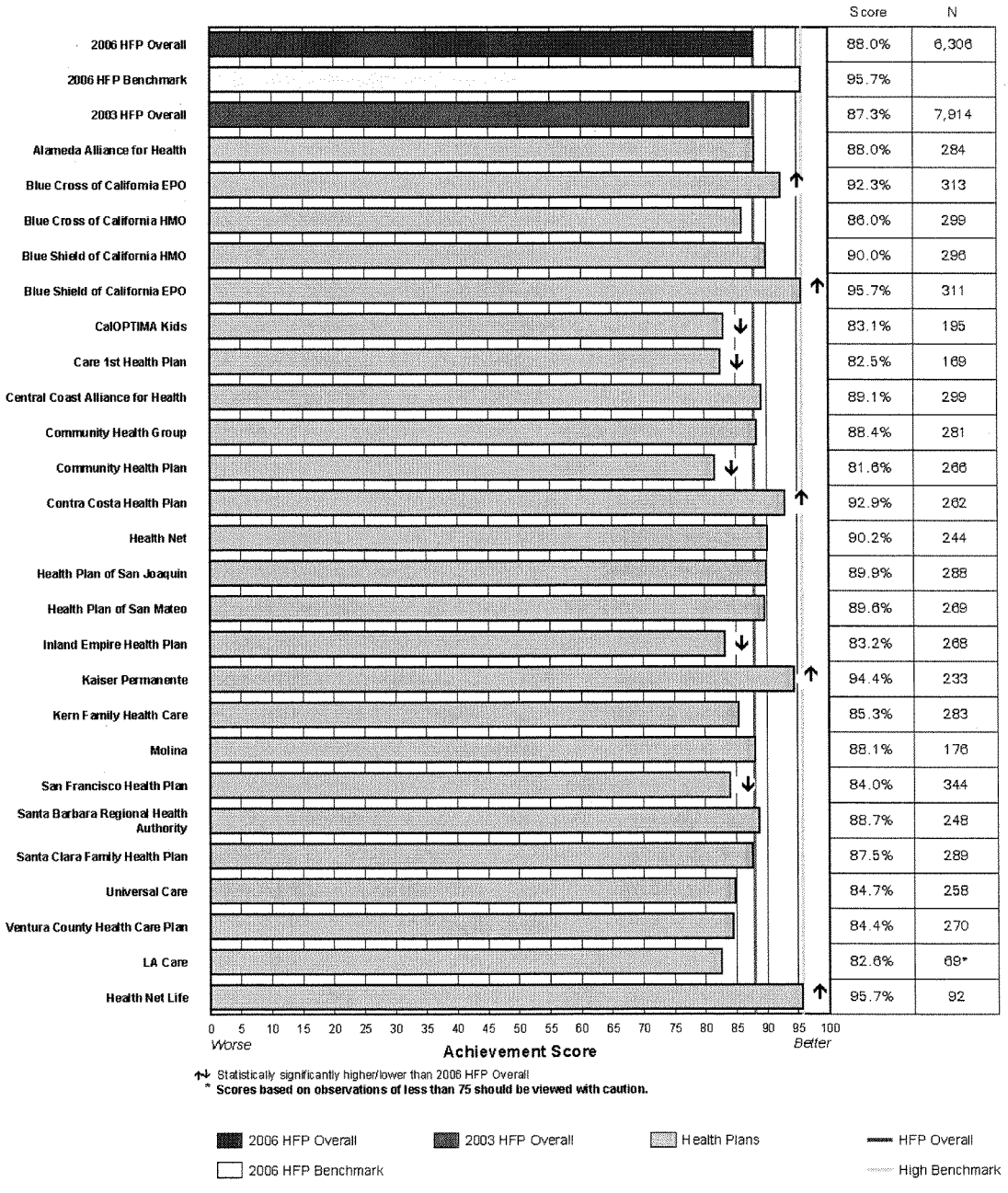


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.

Courteous and Helpful Office Staff

Composite Score

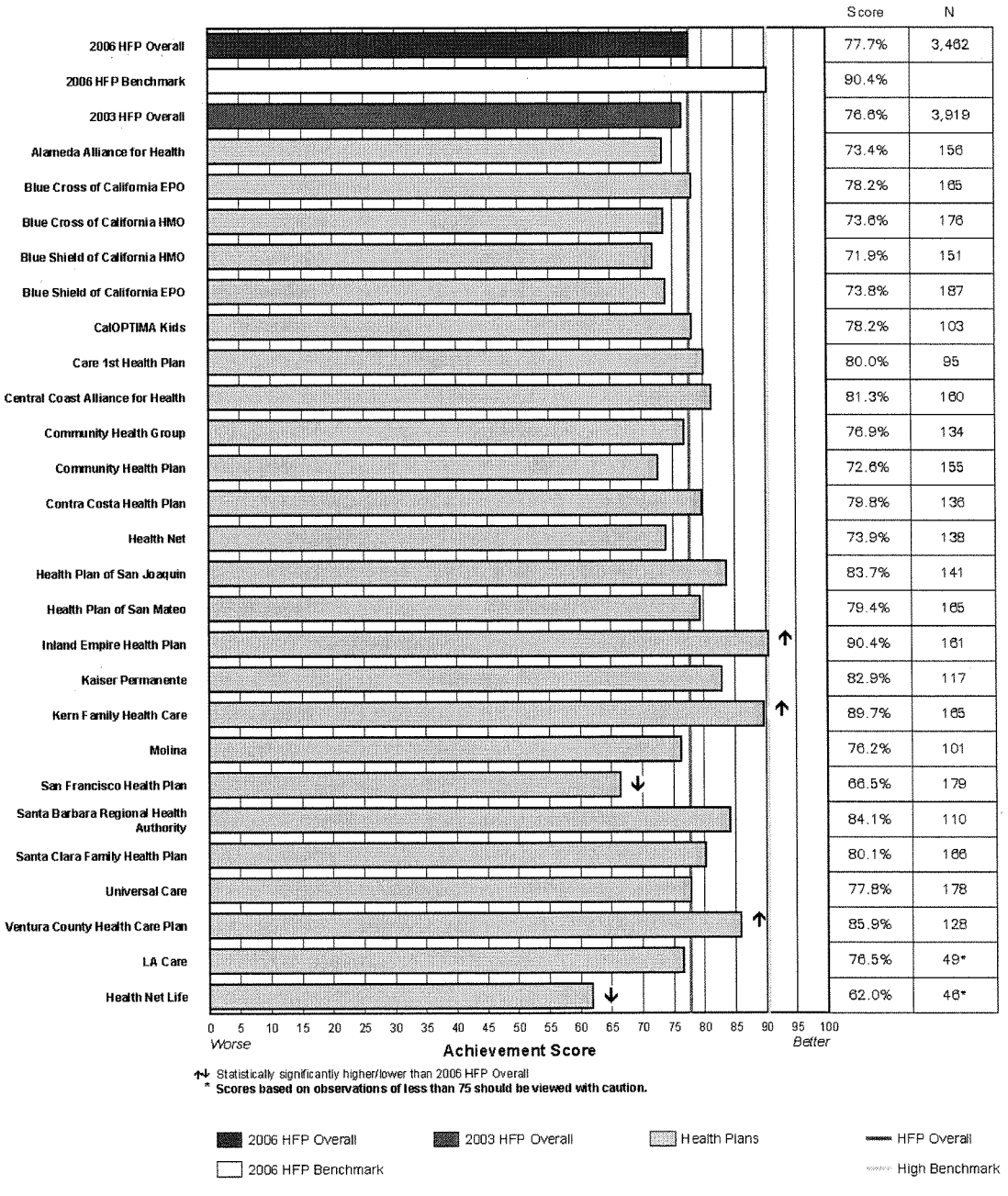


Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.

Customer Service

Composite Score



Healthy Families Program

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.

Summary of Composite Score Results

Scores show slight changes from 2003. The following changes occurred in the composite scores from 2003 to 2006:

- The rating of *Getting Needed Care* decreased slightly from 2003 (86.3%) to 2006 (85.3%).
- The rating of *Getting Care Quickly* increased slightly from 2003 (63.4%) to 2006 (64.6).
- The rating of *How Well Doctors Communicate* increased from 2003 (87.5%) to 2006 (88.8%).
- The rating of *Courteous and Helpful Office Staff* increased slightly from 2003 (87.3%) to 2006 (88%).
- The rating of *Customer Service* increased slightly from 2003 (76.6%) to 2006 (77.7%).

Table 4 shows each plan having composite scores that fell significantly above or below the program average. The following plans had achievement scores that were significantly above the program average in two or more domains:

- Blue Cross EPO and Kaiser Permanente achieved above average scores in four of the five domains.
- Blue Shield EPO achieved above average scores in three of the five domains.
- Health Net, Health Net Life and Ventura County Health Plan achieved above average scores in two of the five domains.

The following plans had achievement scores that were significantly below the program average in two or more domains:

- San Francisco Health Plan received below average scores in four of the five domains.
- Care 1st Health Plan, Community Health Plan and Inland Empire Health Plan received below average scores in three of the five domains.

Table 4 – Statistically Significantly Higher and Lower than HFP Overall Composite Scores

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Commun-icate	Courteous & Helpful Office Staff	Customer Service
Alameda Alliance					
Blue Cross – EPO	▲	▲	▲	▲	
Blue Cross – HMO		▼			
Blue Shield – EPO		▲	▲	▲	
Blue Shield – HMO	▼				
CalOptima				▼	
Care 1st Health Plan		▼	▼	▼	
Central Coast Alliance for Health	▲				
Community Health Group					
Community Health Plan	▼		▼	▼	
Contra Costa Health Plan				▲	
Health Net		▲	▲		
Health Net Life			▲	▲	▼
Health Plan of San Joaquin	▲				
Health Plan of San Mateo	▲				
Inland Empire Health Plan		▼	▼	▼	▲
Kaiser Permanente	▲	▲	▲	▲	
Kern Family Health Care			▼		▲
LA Care		▼			
Molina	▼				
San Francisco Health Plan		▼	▼	▼	▼
Santa Barbara Regional Health Authority	▲				
Santa Clara Family Health Plan					
Universal Care*					
Ventura County Health Plan	▲				▲

* *Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.*

▲ = Statistically significantly higher than HFP Overall Rating Scores

▼ = Statistically significantly lower than HFP Overall Rating Scores

Table 5 shows changes in plan scores that have increased or decreased 4 or more percentage points from 2003 to 2006.

Table 5 - Plan Performance Changes in Overall Composite Scores from 2003 to 2006

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Commun-icate	Courteous & Helpful Office Staff	Customer Service
Alameda Alliance					
Blue Cross – EPO					
Blue Cross – HMO					↓ (6%)
Blue Shield – EPO					↑ (6%)
Blue Shield – HMO					
CalOptima					
Care 1st Health Plan					
Central Coast Alliance for Health					
Community Health Group				↑ (4%)	↓ (5%)
Community Health Plan		↑ (6%)			↑ (4%)
Contra Costa Health Plan		↑ (7%)		↑ (5%)	↑ (6%)
Health Net					
Health Net Life					
Health Plan of San Joaquin					↑ (5%)
Health Plan of San Mateo					
Inland Empire Health Plan					↑ (11%)
Kaiser Permanente					
Kern Family Health Care		↑ (4%)			↑ (5%)
LA Care					
Molina	↓ (4%)	↑ (11%)	↑ (7%)	↑ (5%)	↓ 7%)
San Francisco Health Plan				↑ (4%)	
Santa Barbara Regional Health Authority		↓ (7%)			↑ (10%)
Santa Clara Family Health Plan					
Universal Care**					
Ventura County Health Plan					↑ (9%)

** Health Net Life and LA Care are new plans participating in the Healthy Families Program and no data is available for the 2003 survey for comparison*

*** Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey.*

SURVEY RESULTS: CORRELATION OF SCORES AND SATISFACTION

DataStat, Inc. conducted three analyses in addition to the overall and individual plan scores. The analyses were used to illustrate the program's strongest and weakest areas of performance and the top ten questions that were highly correlated with satisfaction. The areas of strongest and weakest performance are based on the highest and lowest achievement score for a particular question. Questions were identified as having a high positive performance if their achievement score was greater than or equal to eighty-five percent (85%). There were five items that had over ninety percent (90%) of subscribers responding positively. These items are identified in Table 6. These five items were not highly correlated with overall satisfaction. Questions were identified as having a low positive performance if their achievement score was lower than eighty-five percent (85%). There were four items that had less than eighty-five percent (85%) of subscribers responding positively. These items are identified in Table 7. The weakest plan

performance areas were identified in the questions that were highly correlated with satisfaction. A correlation coefficient of 0.40 or greater indicates a relatively high correlation with plan satisfaction. Coefficients less than 0.40 indicate a low correlation with plan satisfaction.

Table 6 – Areas of Strongest Performance

Question	HFP Achievement Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
No problem with paperwork for health plan	94.3%	N (0.16)	Single Item Measure*
Did not call or write to health plan with complaint or problem	94.2%	N (0.19)	Single Item Measure*
Doctors usually or always showed respect	93.3%	N (0.27)	How Well Doctors Communicate
No problems w/delays in child's health care while awaiting approval	93.1%	N (0.23)	Getting Needed Care
Doctors usually or always listened carefully	91.5%	N (0.31)	How Well Doctors Communicate

(*Single item measures are questions in the survey that do not fall into the ratings or composite group categories.)

Table 7 – Areas of Weakest Performance

Question	HFP Achievement Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
Able to get help needed when you called child's health plan's customer service	75.4%	Y (0.43)	Customer Service
Overall rating of specialist	81.6%	Y (0.45)	Overall Ratings
Overall rating of health care	80.4%	Y (0.58)	Overall Ratings
Overall rating of personal doctor or nurse	82.6%	Y (0.48)	Overall Ratings

There were several other areas that were moderately correlated with satisfaction. These are shown in Table 8.

Table 8 – Other Items Correlated with Satisfaction

Question	HFP Achievement Score	Correlation with Satisfaction (Yes or No)	Composite Group
Able to find or understand information in written materials	77.0%	N (0.33)	Customer Service
Able to get a personal doctor or nurse for child you are happy with	79.9%	N (0.36)	Getting Needed Care
Able to get referral to a specialist for child	62.8%	N (0.35)	Getting Needed Care
Able to get the care for child believed necessary	79.4%	N (0.31)	Getting Needed Care
Child usually or always got an appt. for routine care as soon as wanted	79.9%	N (0.29)	Getting Care Quickly

SURVEY RESULTS: COMPARISON TO NATIONAL SCHIP AND MEDICAID

The program's performance in the overall ratings is consistent with scores compared to National SCHIP and National Medicaid programs.

Table 9 - Comparison of HFP, National SCHIP & National Child Medicaid for Ratings Questions

Rating Questions Definition of Achievement Scores (7,8,9,10)	2006 HFP	2006 National SCHIP*	2006 National Child Medicaid*
Health Plan	93%	91%	89%
Health Care	90%	92%	91%
Personal Doctor or Nurse	91%	92%	91%
Specialist	89%	88%	88%

*Comparison data taken from the 2006 CAHPS® Benchmarking Database

For the composite scores, the Program's performance for *Getting Needed Care* was significantly above National SCHIP and National Medicaid child scores. Once again, the HFP scores for the *Getting Care Quickly* composite continue to be significantly lower in comparison to the SCHIP and Medicaid scores. However, it was about the same for *How Well Doctors Communicate*, *Courteous and Helpful Office Staff* and *Customer Service*.

Table 10 - Comparison of HFP, National SCHIP & National Child Medicaid for Composite Questions

Composite Questions	Definition of Achievement Score	2006 HFP	2006 National SCHIP	2006 National Child Medicaid
Getting Needed Care	Not a Problem	85%	78%	74%
Getting Care Quickly	Usually + Always	65%	82%	81%
How Well Doctors Communicate	Usually + Always	89%	93%	91%
Courteous & Helpful Office Staff	Usually + Always	88%	93%	92%
Customer Service	Not a Problem	75%	77%	75%

*Comparison data taken from the 2006 CAHPS® Benchmarking Database

CONCLUSION

Results from this survey reveal key points regarding the Healthy Families Program. The 2006 scores reveal that the Program has maintained the same level of satisfaction since the survey was done in 2003. Families continue to have positive experiences in the Program and with their health plans.

- Eighty-six percent (86%) of families surveyed for the core survey gave their health plan high ratings (at least an 8 on a scale of 0-10).
- Eighty percent (80%) gave their health care a high rating.
- Eighty-three percent (83%) gave their personal doctor or nurse a high rating.
- Eighty-two percent (82%) gave their specialist a high rating.

The data obtained from this survey provides plans and MRMIB with an opportunity to determine areas of best practices and areas needing improvement. HFP health plans are provided with detailed information about their results which they have used to initiate changes in the delivery of services. MRMIB will be meeting with the plans to develop an approach to use the results from the survey for developing collaborative quality improvement activities for deficient areas, and for sharing best practices among participating health plans. In addition, the survey results will be used in conjunction with other quality measurement tools to assess plan performance.

Acknowledgements
Prepared by Mary Watanabe, Benefits Specialist
Assisted by Cristal Schoenfelder, Policy and Operations Manager, Benefits and Quality Monitoring Division

ATTACHMENT III:

HEALTHY FAMILIES PROGRAM 2006 REPORT OF CONSUMER SURVEYS OF DENTAL PLANS

EXECUTIVE SUMMARY

This report summarizes results from the 2006 consumer satisfaction dental survey for the Healthy Families Program (HFP). The survey is an important tool in monitoring quality and access to services. Subscribers receive this information during the Open Enrollment period and in the Program handbook which gives them additional facts about their dental plan choices. California continues to be the only state that has used the dental plan survey. Therefore, there is still no comparative data available.

The results from 2006 survey reveal that the Program has maintained the same level of satisfaction since the survey was done in 2003 with some plans showing improvements or declines in some of the measures as indicated on the following pages. Funding was not allocated for this survey in 2004 and 2005. The results also indicate that subscribers continue to report higher levels of satisfaction with the Exclusive Provider Organizations (EPO's) compared to the Dental Maintenance Organizations (DMO's). However, the overall scores in the dental plan survey continue to be lower than the scores in the health plan survey.

SURVEY METHODOLOGY

MRMIB conducted the survey through an independent survey vendor, DataStat, Inc., using the Consumer Assessment of Dental Plans Survey (D-CAHPS® 1.0)[1] questionnaire. The questionnaire contained 70 questions. Responses to the questions have been summarized into four global ratings and five composite scores. The global ratings included ratings of:

- dental plan
- dental care
- regular dentist
- dental specialist

The composite scores included ratings of:

- getting needed dental care
- getting dental care quickly
- how well dentists communicate
- courteous and helpful office staff
- customer service.

DataStat, Inc. conducted the survey over an 8-week period between August and October 2006. DataStat used a mixed mode (telephone and mail) five-step protocol.

[1] D-CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

The five-step protocol consisted of:

- a pre-notification mailing
- an initial survey mailing
- a reminder postcard to all respondents
- a second survey mailing
- a second reminder postcard to all non-respondents

Telephone follow-up was conducted for non-respondents in English and Spanish only. The D-CAHPS protocol for conducting the telephone follow-up in the Asian languages has not been developed. DataStat consulted with MRMIB staff to develop the pre-notification and follow-up letters based on recommended samples from the D-CAHPS® 1.0 protocol.

The survey was administered in five languages – English, Spanish, Chinese, Korean and Vietnamese. Families with a non-English language preference received two separate survey booklets – one in English and one in the written language selected on the HFP application.

Nine-hundred families per dental plan were sampled for the survey. The sample size for these surveys was determined by the minimum number of returned surveys needed for the analysis and the expected response rates. MRMIB used the sample size recommended for commercial plan surveys because response rates for the HFP surveys have been comparable to commercial plan subscriber response rates.

The six dental plans had sufficient HFP enrollment to provide the target sample. The number of families who were selected for the survey and the distribution of language surveys for each participating dental plan are presented in Table 1.

Table 1 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Access Dental	900	344	489	23	25	19
Delta Dental	900	391	433	44	14	18
Premier Access	900	548	348	1	1	2
Safeguard Dental	900	398	441	38	14	9
Health Net Dental	900	337	523	15	9	16
Western Dental	900	402	480	7	5	6
Total	**5,400**	**2,420**	**2,714**	**128**	**68**	**70**

E= English S=Spanish C=Chinese K=Korean V=Vietnamese

Table 1 shows that most of the surveys were distributed in English and Spanish. Chinese, Korean and Vietnamese surveys comprised five percent (5%) of the total sample.

SURVEY RESULTS: OVERALL RATINGS

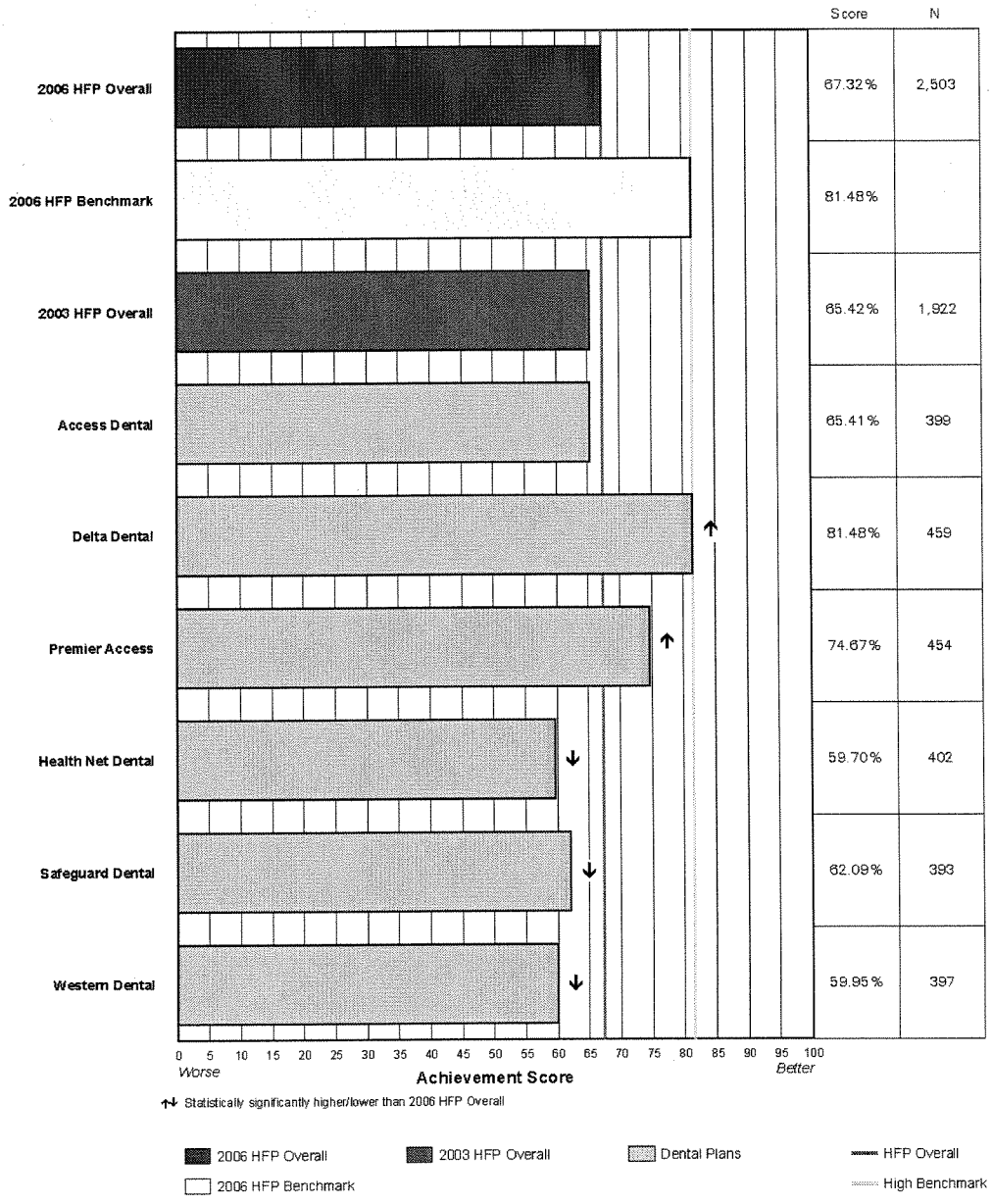
The dental plans had an adequate number of returned surveys to permit the analysis for plan-to-plan comparisons. The minimum number of responses needed for the analysis was 411 completed surveys per plan, which is the target number that (National Committee for Quality Assurance (NCQA) defines for accreditation purposes. This goal allows for at least 100 responses per question for a comparative analysis and is comparable to most types of statistical testing. Tests are considered statistically significant when the number of cases used to compute each score is 30 or greater.

For the four rating questions, a 10-point scale was used to assess overall experience with dental plans, dental care, providers, and specialists. The scale uses "0" to represent the worst and "10" to represent the best score. The achievement scores for these questions were determined by the percentage of families responding to each question using an 8, 9 or 10 rating. Individual plan scores for the 2006 survey are compared with the overall program score in 2006 and 2003 and a benchmark. This benchmark is based on the highest score achieved by a participating dental plan with a minimum of 75 responses.

The following pages contain the HFP overall scores and the individual plan results for the overall rating questions. Plans that have achievement scores significantly higher or lower than the overall program score are indicated by a "↑" or "↓" next to their scores.

Overall Ratings

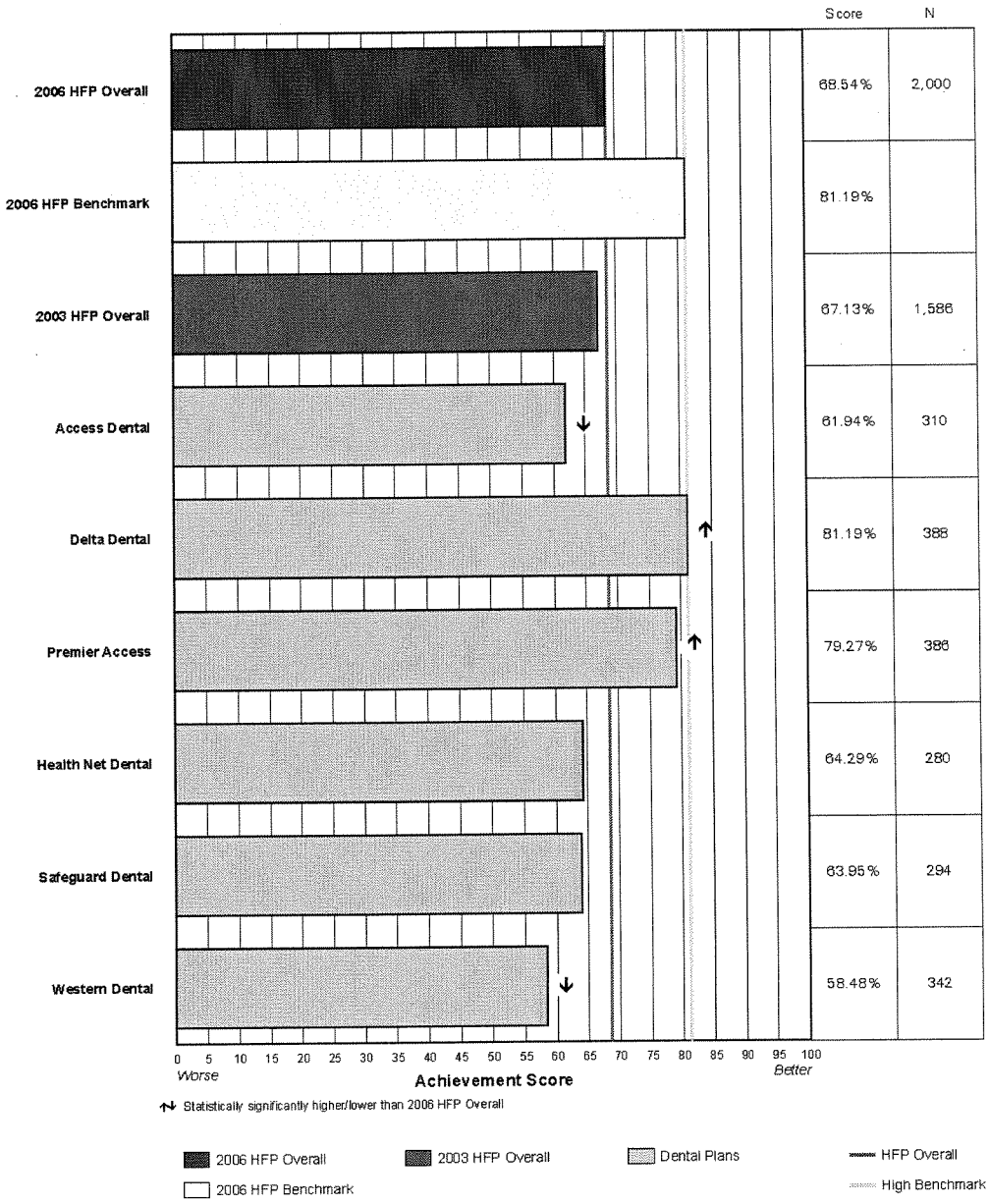
Q52. Overall rating of dental plan



Healthy Families Program

Overall Ratings

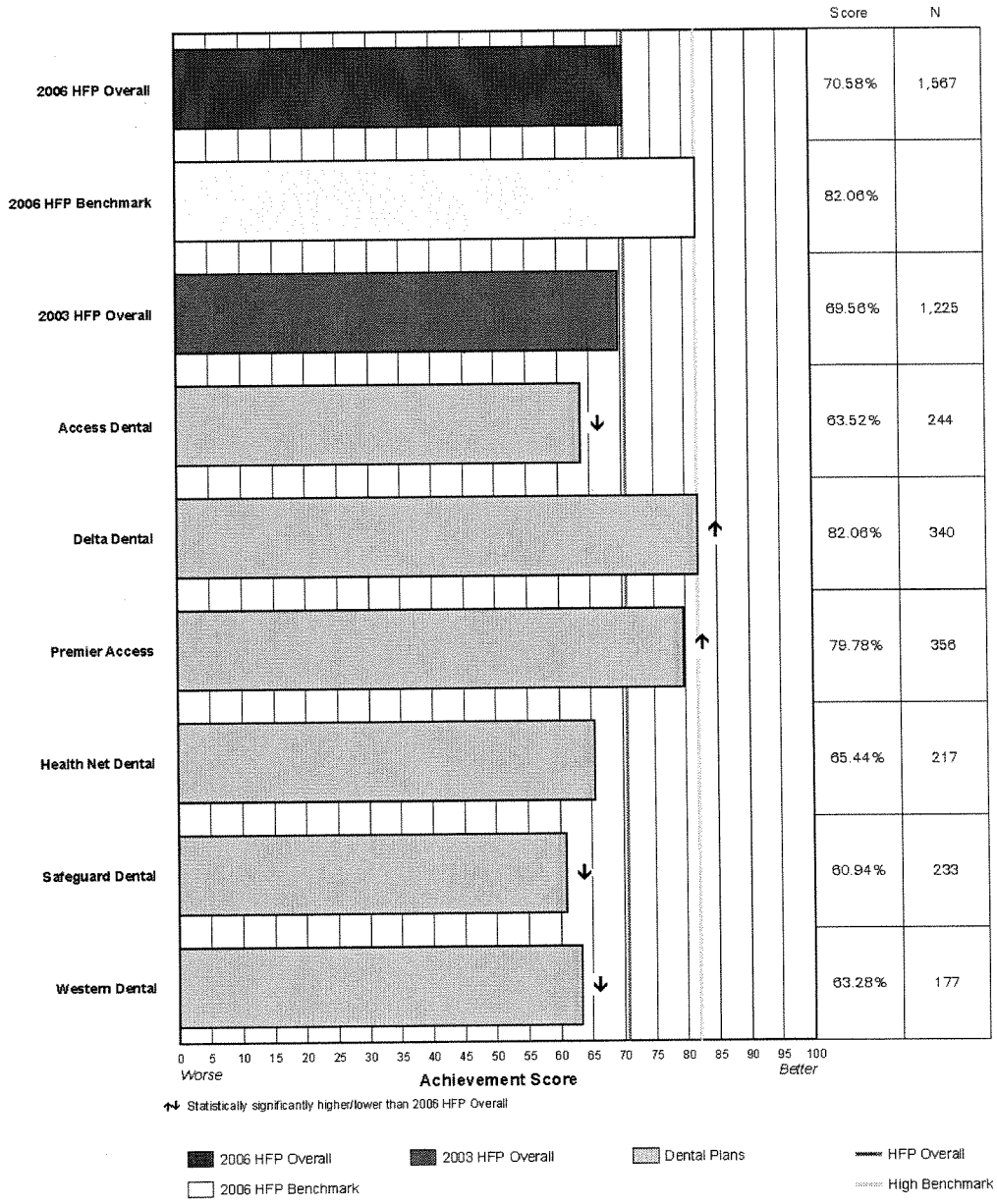
Q40. Overall rating of dental care



Healthy Families Program

Overall Ratings

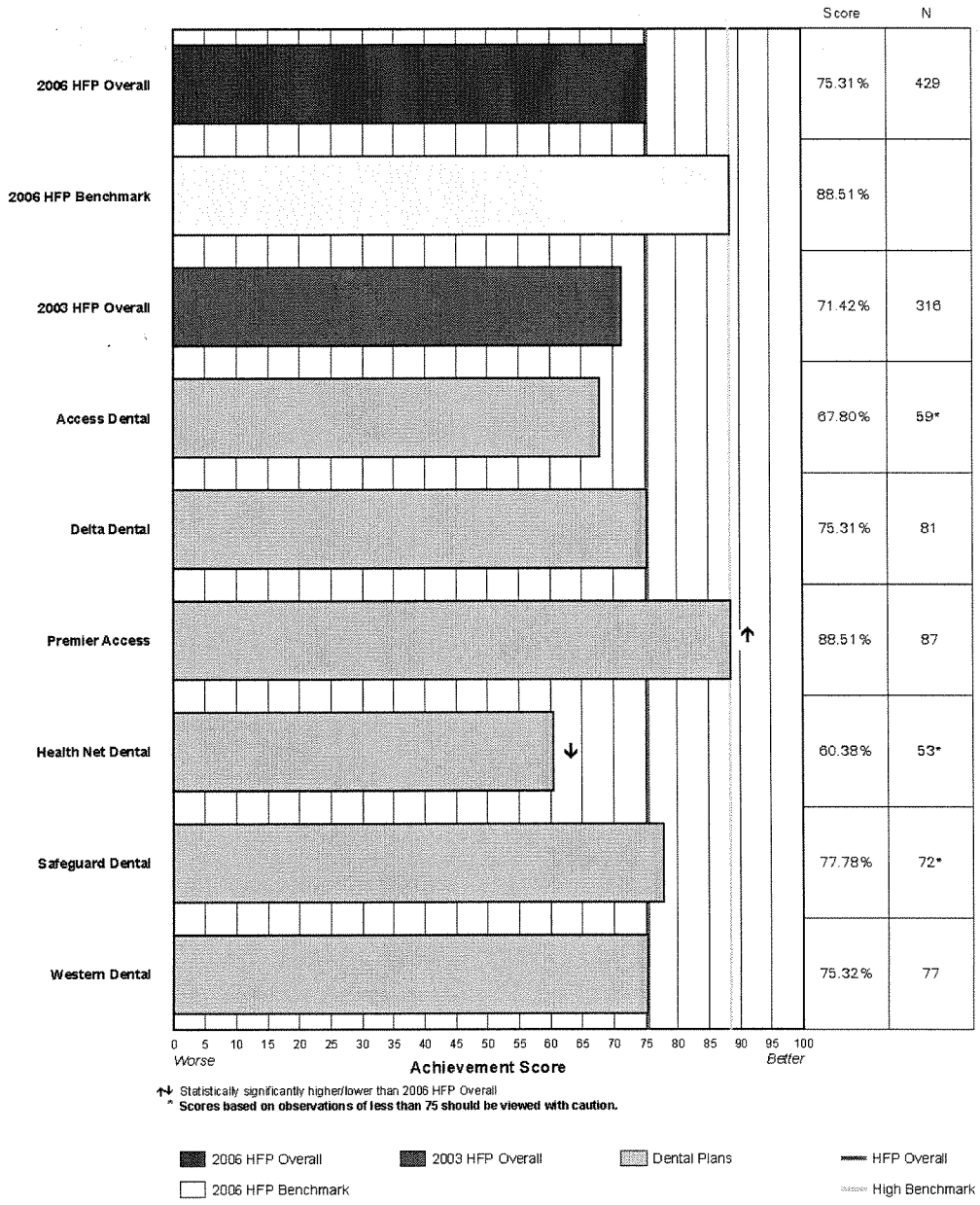
Q9. Overall rating of personal dentist



Healthy Families Program

Overall Ratings

Q14. Overall rating of dental specialist



Healthy Families Program

Summary of Rating Question Responses

The following changes occurred in the overall ratings from 2003 to 2006:

- The rating of *Dental Plan* increased slightly from 2003 (65.4%) to 2006 (67.3%).
- The rating of *Dental Care* increased slightly from 2003 (67.1%) to 2006 (68.5%).
- The rating of *Personal Dentist* increased slightly from 2003 (69.6%) to 2006 (70.6%).
- The rating of *Dental Specialist* increased from 2003 (71.4%) to 2006 (75.3%).

None of the above increases are statistically significant.

Table 2 shows whether the plan results for the ratings questions were statistically significantly above or below the program average score for 2006.

The following plans had achievement scores that were significantly above the program average in two or more questions:

- Premier Access achieved above average scores in all four questions.
- Delta Dental achieved above average scores in three of the four questions.

The following plans had achievement scores that were significantly below the program average in two or more questions:

- Western Dental received below average scores in three of the four questions.
- Access Dental, Health Net Dental and Safeguard Dental received below average scores in two of the four questions.

Table 2 – Statistically Significantly Higher or Lower than HFP Overall Ratings Scores

Dental Plan	Overall Dental Plan	Overall Dental Care	Overall Personal Dentist	Overall Dental Specialist
Access Dental		▼	▼	
Delta Dental	▲	▲	▲	
Health Net Dental	▼			▼
Premier Access	▲	▲	▲	▲
Safeguard Dental	▼		▼	
Western Dental	▼	▼	▼	

▲ = Statistically significantly higher than HFP Overall Rating Scores
▼ = Statistically significantly lower than HFP Overall Rating Scores

Table 3 shows changes in plan scores that have increased or decreased 4 or more percentage points from 2003 to 2006.

Table 3 – Plan Performance Changes in Overall Ratings from 2003 to 2006

Dental Plan	Overall Dental Plan	Overall Dental Care	Overall Personal Dentist	Overall Dental Specialist
Access Dental	↑ (5%)			
Delta Dental			↑ (5%)	
Health Net Dental		↑ (5%)	↑ (5%)	↓ (6%)
Premier Access	↑ (10%)			↑ (13%)
Safeguard Dental*				
Western Dental*				

* Safeguard Dental and Western Dental are new plans participating in the Healthy Families Program and no data is available for the 2003 survey for comparison.

SURVEY RESULTS: COMPOSITE SCORES

The composite score is made up of questions that are grouped by related broad domains of performance. An example of this grouping, *Getting Dental Care Quickly,* includes questions about getting advice by phone, about how soon appointments were scheduled, and about time spent waiting in the dentist's office. The achievement score for each composite is determined by the percentage of families who respond positively to each question that comprises the composite. A response is considered positive if the answers are "not a problem" for the questions comprising the *Getting Needed Dental Care* and *Customer Service* composites, and "usually" and "always" for the *Getting Dental Care Quickly*, *How Well Dentists Communicate*, and *Courteous and Helpful Office Staff* composites.

The survey questions that comprise each composite score are listed below.

"Getting Needed Dental Care"

- Able to get your child a dental office or clinic you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's dental care while awaiting approval

"Getting Dental Care Quickly"

- Usually or always got help of advice needed of child
- Child usually or always got an appointment to fill or treat a cavity as soon as wanted
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for mouth pain or dental problem as soon as wanted
- Child never or sometimes waited more than 15 minutes in dentist's office or clinic

"How Well Dentists Communicate"

- Dentists usually or always listened carefully
- Never or sometimes had a hard time speaking with or understanding dentist because you spoke different languages
- Dentists usually or always explained things in an understandable way
- Dentists usually or always showed respect
- Dentists usually or always spent enough time with child

"Courteous and Helpful Office Staff"

- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

"Customer Service"

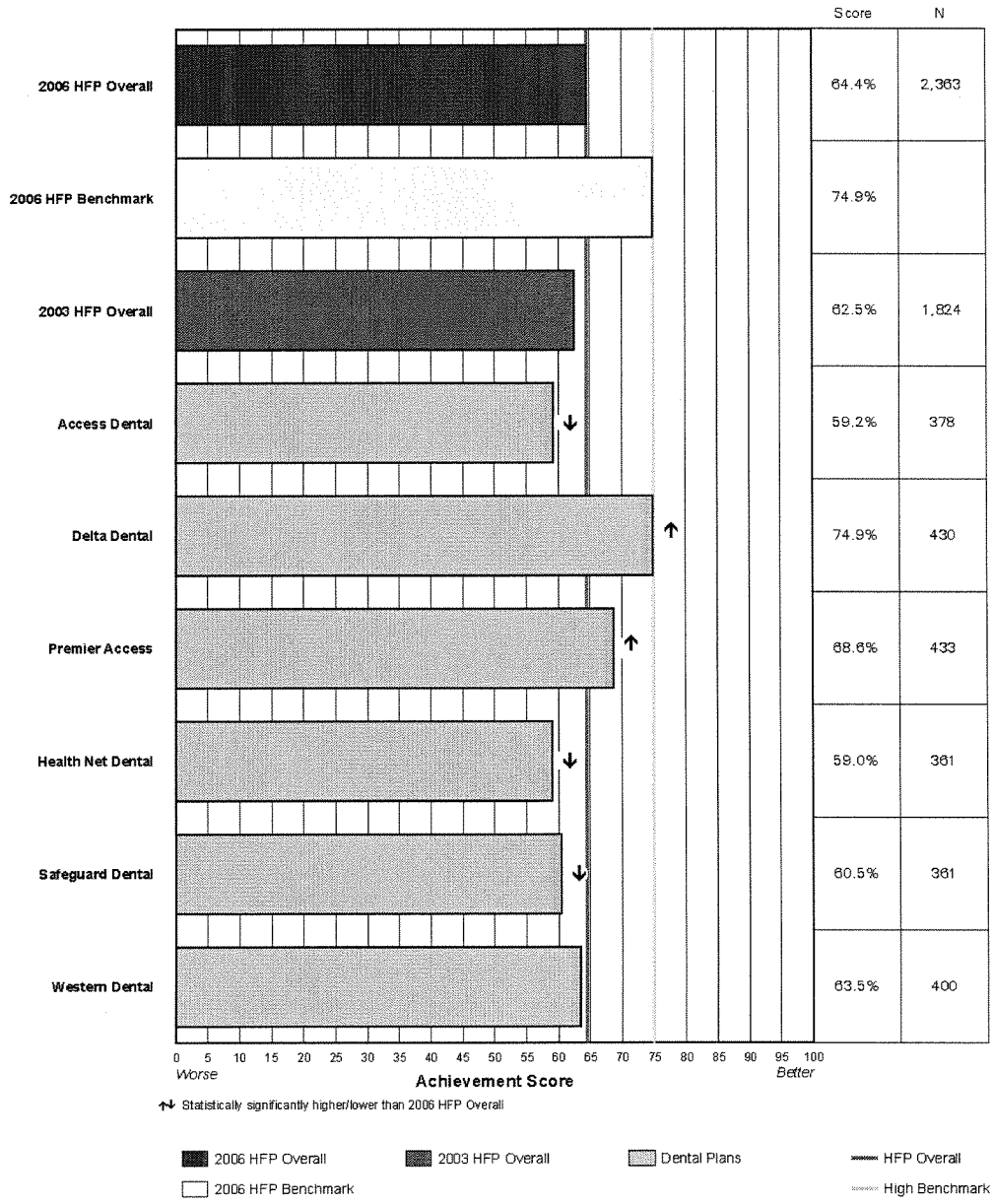
- Able to find or understand information in written materials
- Able to get help needed when you called child's dental plan's customer service

Meaningful differences in the composite scores from one year to the next are more appropriately evaluated by examining changes in the scores of the individual questions that make up each composite score rather than testing for statistical significance.

The following pages contain the HFP overall scores and the individual plan results for the composite scores. Plans that have achievement scores significantly higher or lower than the overall program score are indicated by a "↑" or "↓" next to their scores.

Getting Needed Dental Care

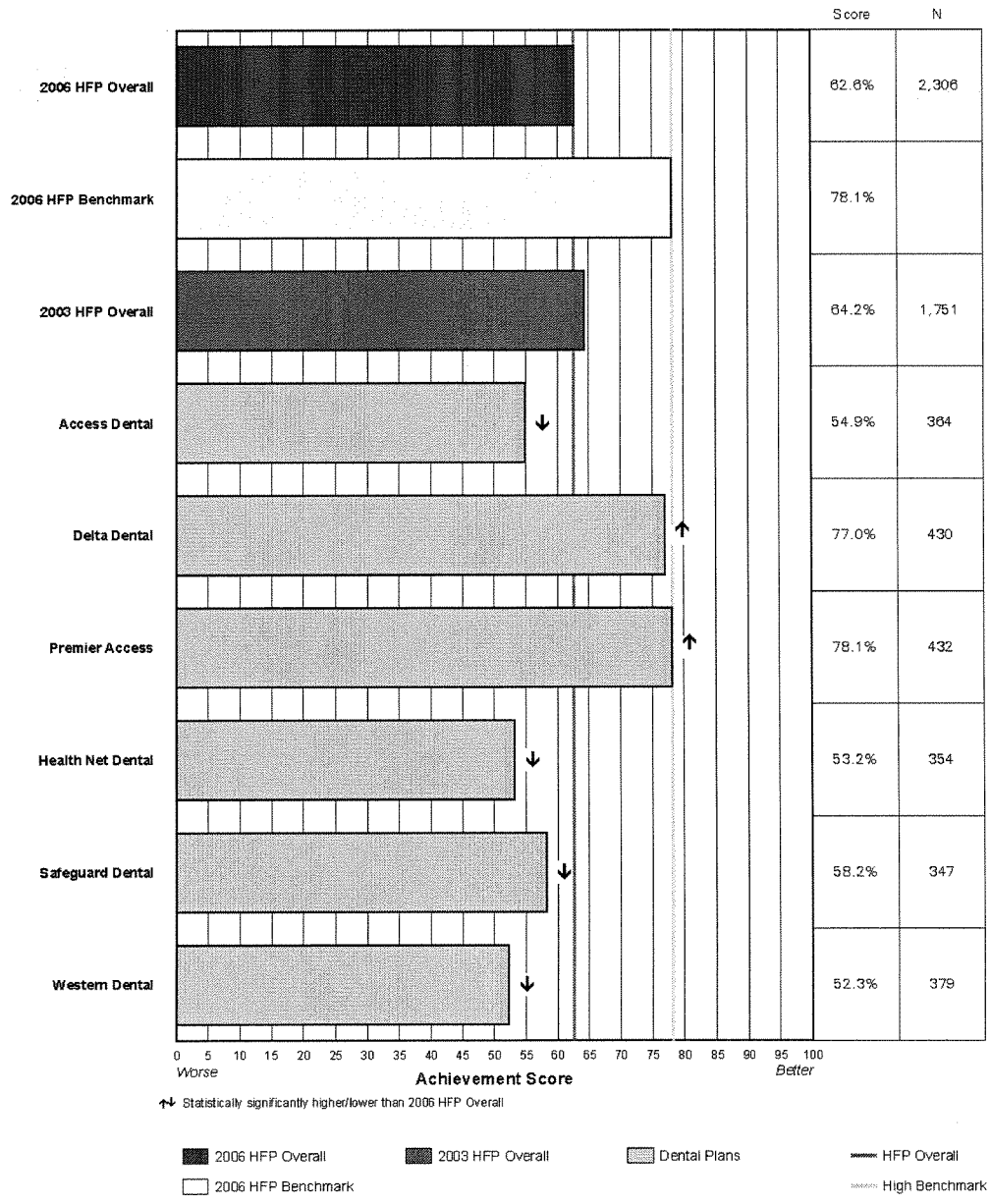
Composite Score



Healthy Families Program

Getting Dental Care Quickly

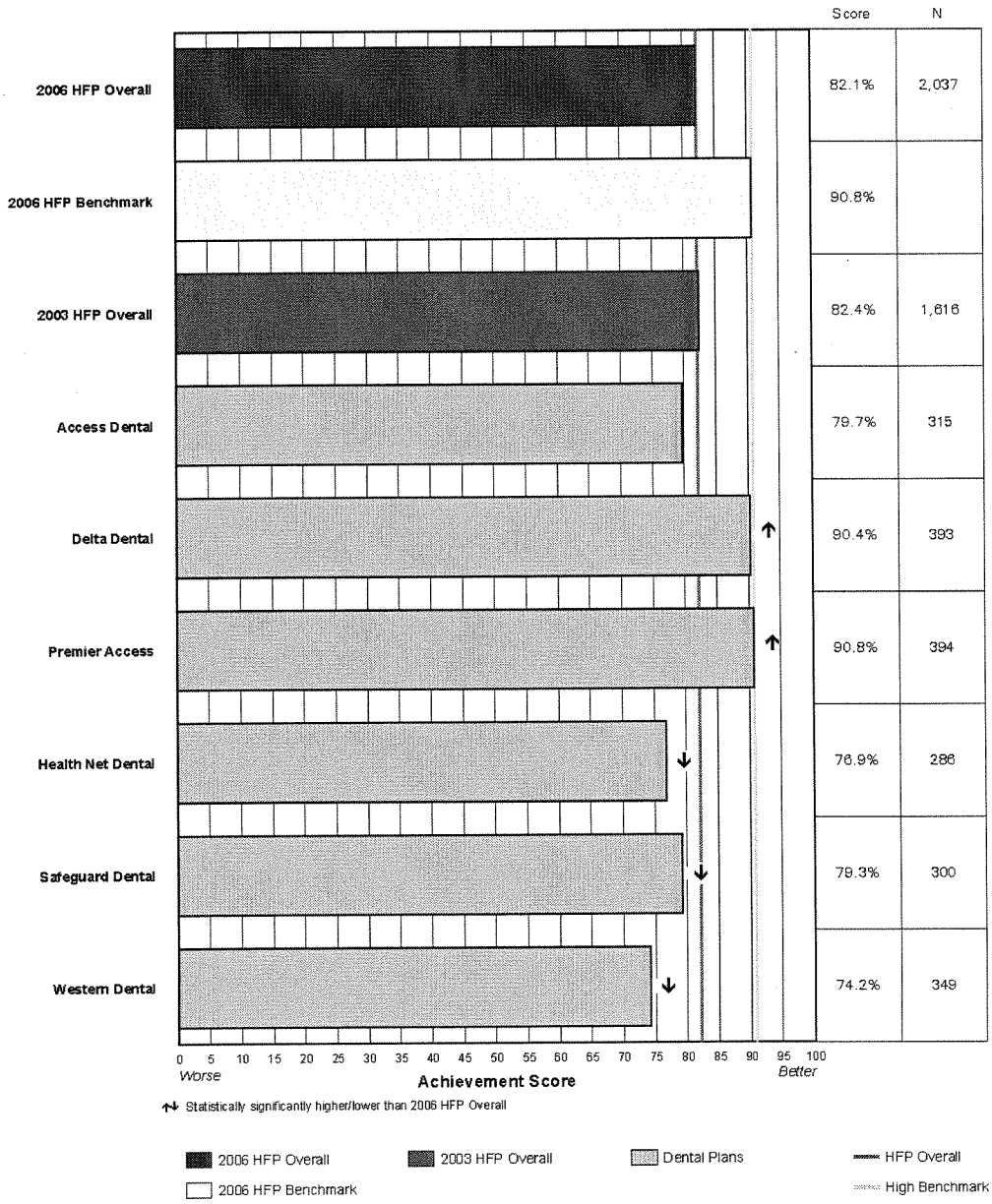
Composite Score



Healthy Families Program

How Well Dentists Communicate

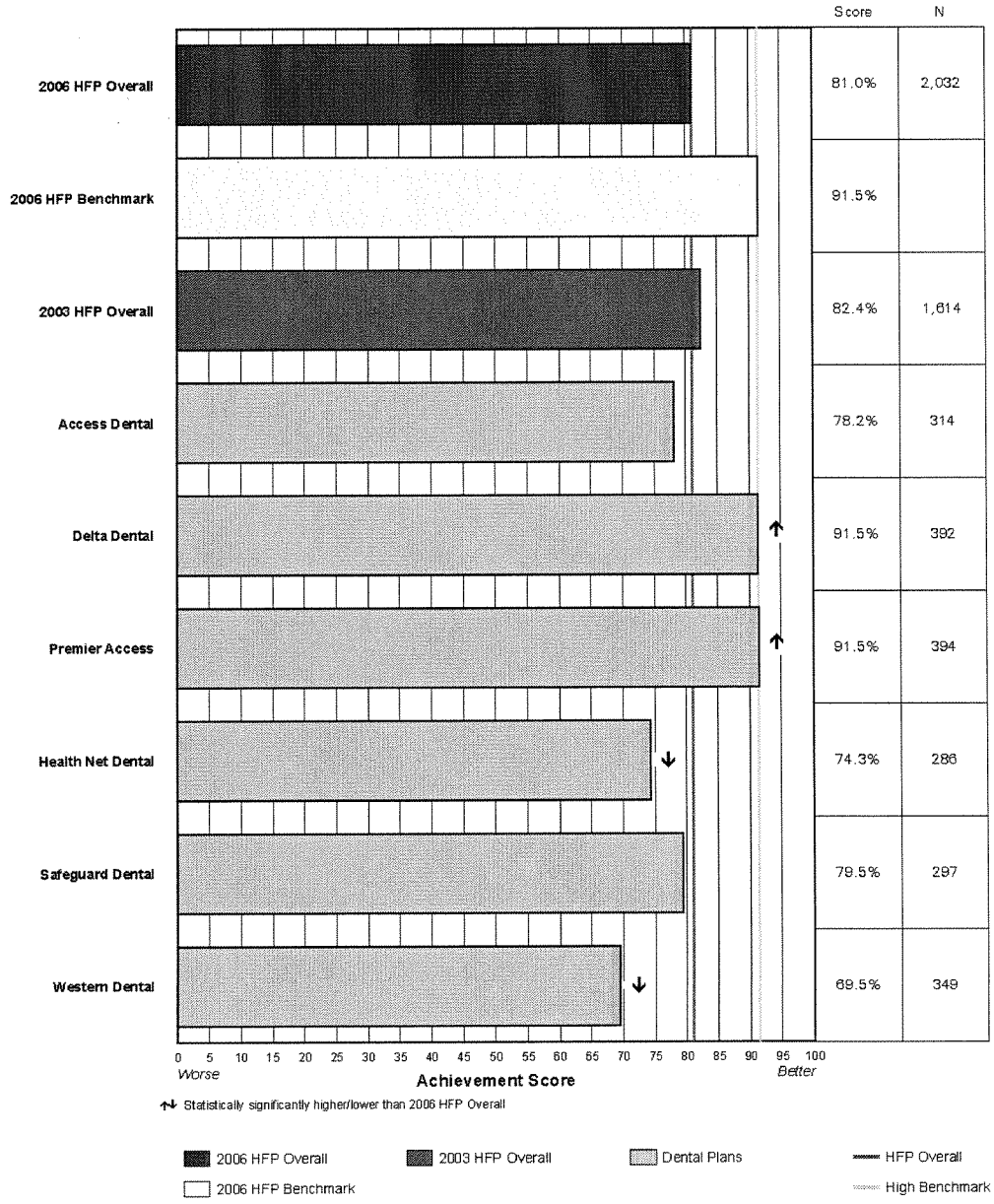
Composite Score



Healthy Families Program

Courteous and Helpful Office Staff

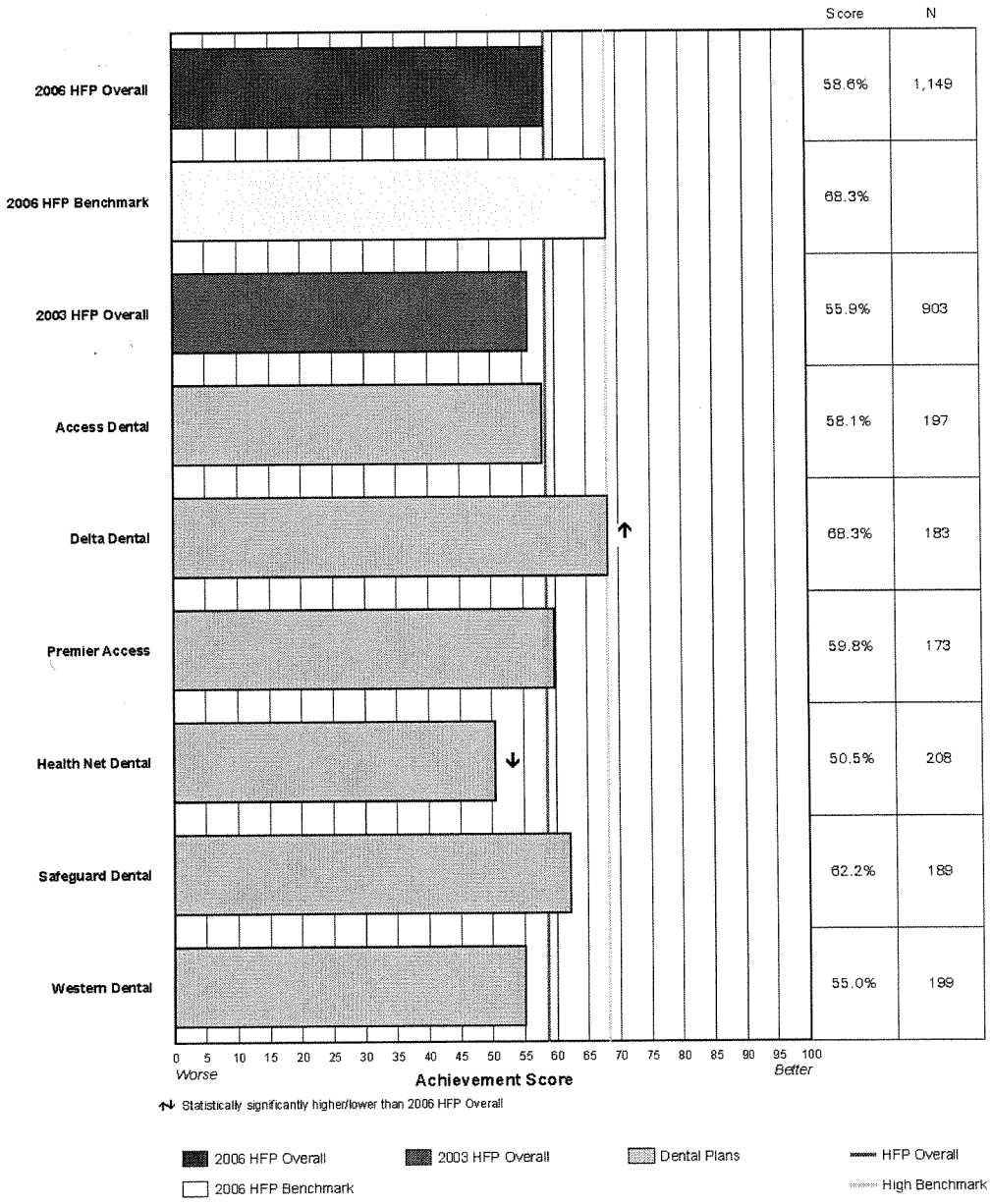
Composite Score



Healthy Families Program

Customer Service

Composite Score



Healthy Families Program

Summary of Composite Score Results

Scores generally remained the same from 2003. The following changes occurred in the composite scores from 2003 to 2006:

- The rating of *Getting Needed Dental Care* increased slightly from 2003 (62.5%) to 2006 (64.4%).
- The rating of *Getting Dental Care Quickly* decreased slightly from 2003 (64.2%) to 2006 (62.6%).
- The rating of *How Well Dentists Communicate* remained about the same from 2003 (82.4%) to 2006 (82.1%).
- The rating of *Courteous and Helpful Office Staff* decreased slightly from 2003 (82.4%) to 2006 (81%).
- The rating of *Customer Service* increased from 2003 (55.9%) to 2006 (58.6%).

Table 4 shows each plan having composite scores that fell significantly above or below the program average. The following plans had achievement scores that were significantly above the program average in two or more domains:

- Delta Dental achieved above average scores in all five domains.
- Premier Access achieved above average scores in all five domains.

The following plans had achievement scores that were significantly below the program average in two or more domains:

- Health Net Dental received below average scores in all five domains.
- Safeguard Dental and Western Dental received below average scores in three of the five domains.
- Access Dental received below average scores in two of the five domains.

Table 4 – Statistically Significantly Higher or Lower than HFP Overall Composite Scores

Dental Plan	Getting Needed Dental Care	Getting Dental Care Quickly	How Well Dentists Communicate	Courteous and Helpful Office Staff	Customer Service
Access Dental	▼	▼			
Delta Dental	▲	▲	▲	▲	▲
Health Net Dental	▼	▼	▼	▼	▼
Premier Access	▲	▲	▲	▲	
Safeguard Dental	▼	▼	▼		
Western Dental		▼	▼	▼	

▲ = Statistically significantly higher than HFP Overall Rating Scores
▼ = Statistically significantly lower than HFP Overall Rating Scores

Table 5 shows changes in plan scores that have increased or decreased 4 or more percentage points from 2003 to 2006.

Table 5 – Plan Performance Changes in Overall Ratings from 2003 to 2006

Dental Plan	Getting Needed Dental Care	Getting Dental Care Quickly	How Well Dentists Communicate	Courteous and Helpful Office Staff	Customer Service
Access Dental					↑ (4%)
Delta Dental					↑ (7%)
Health Net Dental		↓ (7%)		↓ (4%)	↓ (6%)
Premier Access	↑ (4%)				
Safeguard Dental*					
Western Dental*					

* Safeguard Dental and Western Dental are new plans participating in the Healthy Families Program and no data is available for the 2003 survey.

SURVEY RESULTS: CORRELATION OF SCORES AND SATISFACTION

DataStat, Inc. conducted three analyses in addition to the overall and individual plan scores. The analyses were used to illustrate the program's strongest and weakest areas of performance and the top ten questions that were highly correlated with satisfaction. The areas of strongest and weakest performance are based on the highest and lowest achievement score for a particular question. Questions were identified as having a high positive performance if their achievement score was greater than or equal to eighty-five percent (85%). The question "Dentists usually or always showed respect" had greater than eighty-five percent (85%) of subscribers responding positively and it was highly correlated with satisfaction as shown in Table 6. Questions were identified as having a low positive performance if their achievement score was lower than 85 percent. There are eleven items that had less than eighty-five percent (85%) of subscribers responding positively. These items are identified in Table 7. The weakest plan performance areas were identified in the questions that were highly correlated with satisfaction.

A correlation coefficient of 0.40 or greater indicates a relatively high correlation with plan satisfaction. Coefficients less than 0.40 indicate a low correlation with plan satisfaction.

Table 6 – Area of Strongest Performance

Question	HFP Achievement Score	Correlation with overall Satisfaction (Yes or No)	Composite Group
Dentists usually or always showed respect	86.7%	Y (0.42)	How Well Dentists Communicate

Table 7 – Areas of Weakest Performance

Question	HFP Achievement Score	Correlation with Satisfaction (Yes or No)	Composite Group
Able to get help needed when you called child's dental plan's customer service	54.4%	Y (0.44)	Customer Service
Child usually or always got an interpreter when needed	58.4%	Y (0.53)	How Well Dentists Communicate
Child usually or always got needed care for mouth pain or dental problem as soon as wanted	59.2%	Y (0.47)	Getting Dental Care Quickly
Usually or always got help or advice needed for child	66.9%	Y (0.41)	Getting Dental Care Quickly
Overall rating of dental care	68.5%	Y (0.61)	Overall Ratings
Overall rating of personal dentist	70.6%	Y (0.53)	Overall Ratings
Overall rating of dental specialist	75.3%	Y (0.44)	Overall Ratings
Usually or always got an interpreter when needed	76.1%	Y (0.42)	How Well Dentists Communicate
Dentists usually or always spent enough time with child	76.1%	Y (0.43)	How Well Dentists Communicate
Office Staff usually or always helpful	78.0%	Y (0.45)	Courteous and Helpful Office Staff
Dentists usually or always listened carefully	78.8%	Y (0.43)	How Well Dentists Communicate

CONCLUSION

The results of the survey show significant variations in the scores between the dental plan types. As seen in previous years, the EPO dental plans had higher scores than the DMO dental plans.

The data obtained from this survey provides plans and MRMIB with an opportunity to determine areas of best practices and areas needing improvement. HFP dental plans are provided with detailed information about their results which they have used to initiate changes in the delivery of services. MRMIB will be meeting with the plans to develop an approach to use the results from the survey for developing collaborative quality improvement activities for deficient areas and for sharing best practices among participating health plans. In addition, the survey results will be used in conjunction with other quality measurement tools to assess plan performance.

Acknowledgements
Prepared by Mary Watanabe, Benefits Specialist
Assisted by Cristal Schoenfelder, Policy and Operations Manager, Benefits and Quality Monitoring Division

ATTACHMENT IV:

HEALTHY FAMILIES PROGRAM 2006 REPORT OF YOUNG ADULT SURVEY OF HEALTH PLANS (YAHCS)

2006 Report of Young Adult Survey of Health Plans

EXECUTIVE SUMMARY

This report summarizes the results from the 2006 young adult health care survey for the Healthy Families Program (HFP). The survey provides a comprehensive tool for assessing the degree to which teens aged 14 through 18 receive recommended preventive counseling and screening. This is the first year this survey has been administered for the HFP. The results provide plans, providers and consumers with information about the quality of preventive services teens receive.

Surveys of the teen population have typically yielded low response rates. In an effort to increase the response rate, MRMIB staff proposed a few changes to the survey process. First, the surveys were administered in the summer rather than the fall in the hopes that there would be a greater response from teens that were home on summer vacation and able to complete the survey without their parent's supervision. Also, MRMIB staff proposed administering the survey on the web for teens who were more comfortable using the web and more likely to complete the survey in this format. Two hundred and fourteen usable surveys were completed on the web.

The results from the 2006 survey provide the first look at the experience of teens in the HFP and their unique health care needs. The majority of teens in the HFP are seeing a doctor for routine care and do not have a problem getting care when they need it. They also found counseling to be helpful when they received it and were able to communicate with their doctors. However, the survey results indicate several opportunities to improve these encounters. The teens in the HFP had lower scores, based on the Child and Adolescent Health Measurement Initiative (CAHMI) benchmark database, compared to teens in other Medicaid and State Children's Health Insurance Programs (SCHIP). The lower scores were in three of the four quality measures related to preventive screening and counseling. Lower scores related to receiving care in a private and confidential setting were also reported.

SURVEY METHODOLOGY

MRMIB conducted the survey through an independent survey vendor, DataStat, Inc., using the Young Adult Health Care Survey (YAHCS), which was developed and tested nationally by CAHMI and the Foundation for Accountability (FAACT). The questionnaire contains 58 questions addressing areas such as:

- the quantity and quality of preventive screening and counseling for risky behaviors;
- whether counseling and screening was provided in a private and confidential setting; and
- assessing the teen's experience of the care provided

The survey included 15 supplemental questions taken from the Consumer Assessment of Health Plan Survey (CAHPS®) supplemental question set and from the FAACT Living with Illness questionnaire.

Responses to the questions have been summarized into eight composite scores and three single item scores. The composite scores addressed the following areas:

- counseling and screening to prevent risky behavior
- counseling and screening to prevent unwanted pregnancy and sexually transmitted diseases (STDs)
- counseling and screening related to diet, weight and exercise
- counseling and screening related to depression, mental health and relationships
- care provided in a confidential and private setting
- helpfulness of counseling provided
- communication and experience of care
- health information

The single item scores addressed the following areas:

- getting care the member or their doctor believed necessary
- having a serious health problem that went untreated
- rating of health status

DataStat, Inc. conducted the survey over an 8-week period between August and October 2006. DataStat used a mixed mode (mail and web survey) five-step protocol. The five-step protocol consisted of:

- a pre-notification mailing
- an initial survey mailing
- a reminder postcard to all respondents
- a second survey mailing
- a second reminder postcard to all non-respondents

The first and second survey mailing included a login and password to a secure website that the teen could access to complete the survey online.

The paper survey was administered in five languages – English, Spanish, Chinese, Korean and Vietnamese. Families with a non-English language preference received two separate survey booklets – one in English and one in the written language selected on the HFP application. The web survey was available in English and Spanish.

The survey target sample goal was nine-hundred families per health plan. Children had to be 14 years old as of April 30, 2006 and had to be continuously enrolled in HFP for at least six months as of April 30, 2006 to be eligible to participate in the survey. Only those teens who did not receive a HFP Consumer Survey for Health Plans were selected to participate

in the YAHCS. There were twenty-five plans identified for participation in the survey. Thirteen plans had sufficient HFP enrollment to provide the target sample. Five plans fell short of the target sample but had a total sample of more than 100. Three plans (Contra Costa Health Plan, Health Plan of San Mateo and Ventura County Health Plan) had a total sample of less than 100 and were included in the overall HFP score, but the individual plan score is not presented. Four plans (Central Coast Alliance for Health, Health Net Life, L.A. Care and Santa Barbara Regional Health Authority) did not have any teens in their sample that were eligible to participate in the survey.

Completed surveys were received from 6,632 members and the overall response rate was forty-five percent (45%). The number of families who were selected for the survey and the distribution of language surveys for each participating health plan are presented in Table 1.

Table 1 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Alameda Alliance for Health	900	285	290	282	13	30
Blue Cross - EPO	900	443	420	17	16	4
Blue Cross - HMO	900	401	351	86	47	15
Blue Shield - EPO	487	402	69	8	2	6
Blue Shield - HMO	900	454	274	85	67	20
CalOptima	900	155	600	4	40	101
Care 1st Health Plan	716	156	541	15	2	2
Community Health Group	900	228	655	4	0	13
Community Health Plan	900	203	647	36	12	2
Contra Costa Health Plan	93	39	50	3	0	1
Health Net	900	438	364	70	14	14
Health Plan of San Joaquin	865	361	479	16	1	8
Health Plan of San Mateo	43	14	28	0	0	1
Inland Empire Health Plan	900	341	551	2	1	5
Kaiser Permanente	900	536	330	23	3	8
Kern Family Health Care	900	330	565	1	3	1
Molina	900	314	572	4	3	7
San Francisco Health Plan	797	147	95	547	0	8
Santa Clara Family Health Plan	900	199	468	47	4	182
Universal Care*	766	161	592	2	2	9
Ventura County Health Plan	60	17	42	1	0	0
Total	**15527**	**5624**	**7983**	**1253**	**230**	**437**

E= English S=Spanish C=Chinese K=Korean V=Vietnamese

** Universal Care is no longer participating in the Healthy Families Program, but was included in the 2006 survey.*

Table 1 shows that most of the surveys were distributed in English and Spanish. Chinese, Korean and Vietnamese surveys comprised twelve percent (12%) of the total sample. However, Alameda Alliance for Health's and San Francisco Health Plan's surveys comprise thirty-six percent (36%) and seventy percent (70%) of these languages respectively.

SAMPLE PROFILE

Table 2 shows the demographic characteristics of the overall HFP sample as well as for those who completed the survey in English, Spanish or one of the three Asian languages (Chinese, Korean and Vietnamese).

Table 2 – Demographic Characteristics of Sample

Age (years) *	HFP Overall	Asian Survey	English Survey	Spanish Survey
MEAN	15.7	15.9	15.8	15.7
14 Years	26.6%	24.1%	24.8%	28.4%
15 Years	25.5%	23.0%	25.2%	26.4%
16 Years	23.0%	23.3%	23.6%	22.6%
17 Years	19.1%	23.2%	20.5%	17.0%
18 Years	4.5%	5.2%	5.2%	3.9%
19 Years	0.0%	0.0%	0.0%	0.0%
20 Years	1.3%	1.2%	0.7%	1.6%

Gender	HFP Overall	Asian Survey	English Survey	Spanish Survey
Female	51.5%	47.3%	50.8%	53.1%
Male	48.5%	52.7%	49.2%	46.9%

Race	HFP Overall	Asian Survey	English Survey	Spanish Survey
White	11.1%	0.4%	34.4%	1.8%
African American	2.6%	0.3%	8.4%	0.2%
Asian	23.5%	98.4%	23.5%	0.2%
American Indian or Alaska Native	1.0%	0.1%	2.9%	0.1%
Hispanic or Latino	62.8%	0.1%	34.0%	97.9%
Native Hawaiian or Other Pacific Islander	1.1%	0.3%	3.5%	0.1%

Last Time Teen Had Routine Care	HFP Overall	Asian Survey	English Survey	Spanish Survey
0-6 Months	55.3%	54.8%	56.3%	54.9%
7-12 Months	25.5%	24.6%	24.5%	26.4%
13-24 Months	9.6%	8.7%	9.6%	9.9%
More than two years ago	3.6%	3.0%	3.9%	3.7%
Did not go to Doctor/Clinic for Check-up	5.9%	8.9%	5.7%	5.1%

Where Teen Usually Goes for Medical Care	HFP Overall	Asian Survey	English Survey	Spanish Survey
Doctor's Office or Clinic	74.6%	71.0%	80.9%	72.4%
School Nurse	0.4%	0.5%	0.5%	0.4%
Community Clinic	14.4%	15.4%	8.3%	17.3%
Hospital Clinic	6.3%	8.6%	5.4%	6.2%
Hospital Emergency Room	0.5%	0.2%	0.6%	0.6%
Family Planning Center	0.5%	0.9%	0.3%	0.4%
Urgent Care Clinic	0.8%	0.1%	1.5%	0.6%
No One Usual Place	2.4%	3.4%	2.5%	2.1%

*Children under the age of 18 qualify for HFP and to participate in the survey. However, the age reported above is based on the age that the participant recorded on their survey.

Table 3 shows the health status of the overall HFP sample as well as for those who completed the survey in English, Spanish or one of the three Asian languages.

Table 3 – Health Status of Sample

Health Status	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Excellent	23.8%	30.0%	26.5%	20.6%	18.2%	18.9%	29.5%	22.3%
Very Good	38.0%	37.6%	40.9%	38.9%	35.1%	43.8%	39.8%	35.3%
Good	29.7%	26.9%	26.0%	30.9%	34.6%	30.7%	25.0%	31.9%
Fair	7.6%	5.1%	5.9%	6.5%	10.7%	6.1%	5.2%	9.4%
Poor	0.8%	0.4%	0.7%	0.9%	1.3%	0.6%	0.6%	1.0%

Number of Days Exercised in Last 4 Weeks	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
None	20.6%	14.8%	17.2%	21.5%	28.7%	34.3%	17.0%	18.3%
1 to 9 Days	37.5%	31.0%	35.5%	41.2%	41.9%	36.4%	35.4%	36.9%
10 to 13 Days	12.6%	12.9%	12.6%	13.3%	11.8%	11.1%	13.7%	12.5%
14 to 20 Days	13.7%	17.8%	14.8%	12.6%	9.7%	10.3%	16.1%	13.4%
21 to 28 Days	15.6%	23.6%	19.9%	11.4%	7.9%	7.9%	17.8%	16.8%

Number of Days Pain Bothered You in Last 4 Weeks	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
None	57.1%	65.8%	64.1%	54.6%	44.6%	65.3%	53.4%	56.7%
1 to 3 Days	30.0%	25.0%	25.9%	32.3%	36.4%	26.7%	31.4%	30.2%
4 to 6 Days	7.1%	5.1%	5.5%	7.2%	10.3%	4.7%	8.2%	7.2%
7 to 14 Days	3.4%	2.1%	2.7%	3.6%	5.0%	2.0%	4.1%	3.4%
15 to 28 Days	2.4%	2.1%	1.7%	2.3%	3.6%	1.3%	2.9%	2.6%

Number of Days Health or Emotional Problem Kept You From Ordinary Activities in Last 4 Weeks	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
None	75.5%	83.9%	81.1%	72.4%	65.3%	78.9%	71.6%	76.6%
1 to 3 Days	16.3%	10.5%	13.3%	18.0%	23.1%	15.6%	19.1%	15.0%
4 to 6 Days	4.3%	2.8%	2.8%	5.4%	6.0%	3.6%	4.6%	4.3%
7 to 14 Days	2.0%	1.5%	1.2%	2.0%	3.4%	1.1%	2.4%	2.1%
15 to 28 Days	1.8%	1.4%	1.6%	2.1%	2.2%	0.7%	2.2%	2.0%

Agree with statement: "I am full of energy"	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Completely or mostly agree	80.9%	87.0%	84.2%	78.3%	74.6%	82.9%	82.1%	79.7%
Agree a little or Do not agree	19.1%	13.0%	15.8%	21.7%	25.4%	17.1%	17.9%	20.3%

Agree with statement: "I have a lot of good qualities"	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Completely or mostly agree	87.5%	90.9%	89.6%	84.2%	85.5%	83.5%	91.0%	86.8%
Agree a little or Do not agree	12.5%	9.1%	10.4%	15.8%	14.5%	16.5%	9.0%	13.2%

Agree with statement: "I am satisfied with my life and how I live it"	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Completely or mostly agree	85.4%	90.2%	87.2%	83.6%	80.6%	83.9%	85.9%	85.6%
Agree a little or Do not agree	14.6%	9.8%	12.8%	16.4%	19.4%	16.1%	14.1%	14.4%

Teen completely or mostly agreed with all 3 of the above statements	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Proportion who completely or mostly agreed	69.3%	75.6%	74.0%	65.5%	62.6%	69.1%	71.0%	68.5%

Table 4 shows the scores for depression and risky behaviors for the overall HFP sample as well as for those who completed the survey in English, Spanish or one of the three Asian languages.

Table 4 – Teen Depression and Risky Behaviors

Depression	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Teen Felt Sad Or Hopeless Everyday for Two Weeks or More In a Row	16.7%	9.3%	12.8%	20.8%	23.6%	8.5%	14.7%	20.3%

Smoking	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Teen smoked cigarettes on 1 or more days in the last 30 days	2.6%	0.8%	5.2%	1.5%	3.0%	1.2%	4.0%	2.2%

Drinking	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Teen had at least one drink of alcohol in the last 30 days	10.2%	5.5%	13.1%	8.3%	14.5%	4.6%	10.1%	12.1%

Sexually Active	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Teen has had sexual intercourse	11.5%	4.9%	18.7%	4.2%	19.2%	2.8%	13.3%	13.2%

Routinely Does Not Wear Seatbelt	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
Teen never, rarely or sometimes wears seatbelt	6.0%	6.2%	4.7%	7.3%	5.4%	3.3%	4.5%	7.6%

Count of Teen Depression and Risky Behavior Participation	HFP Overall	Males Under 16	Males 16 and Older	Females Under 16	Females 16 and Over	Asian Survey	English Survey	Spanish Survey
0 out of 5 risky behaviors	68.3%	78.9%	65.9%	70.4%	57.4%	83.8%	69.4%	62.9%
1 out of 5 risky behaviors	21.7%	17.4%	21.5%	21.1%	26.8%	13.2%	20.2%	25.1%
2 out of 5 risky behaviors	6.9%	2.6%	8.0%	6.1%	11.3%	2.2%	7.0%	8.4%
3 out of 5 risky behaviors	2.2%	1.0%	3.2%	1.7%	3.1%	0.6%	2.1%	2.7%
4 out of 5 risky behaviors	0.8%	0.2%	1.5%	0.7%	1.1%	0.2%	1.3%	0.8%
5 out of 5 risky behaviors	0.1%	0.0%	0.0%	0.1%	0.2%	0.0%	0.1%	0.1%

Results from this survey reveal the following key points regarding the HFP teen population:

- Nearly eighty-one percent (81%) of teens received routine care in the last year and eighty-nine percent (89%) received their medical care from either a doctor's office or clinic or from a community clinic.
- Sixty-nine percent (69%) completely or mostly agreed with the statements "I am full of energy", "I have a lot of good qualities" and "I am satisfied with my life and how I live it".
- Sixty-eight percent (68%) reported that they did not feel depressed or engage in any risky behavior such as smoking, drinking, sexual intercourse or not wearing a seat belt.
- Sixty-two percent (62%) reported that they considered themselves to be in excellent or very good health.
- Fifty-eight percent (58%) reported that they exercised less than 9 days in a 4 week period.
- Less than seventeen percent (17%) reported depressive symptoms.

SURVEY RESULTS: COMPOSITE SCORES

The composite score is made up of questions that are grouped by related broad domains of performance. The achievement score for each composite is determined by the percentage of teens who respond positively to each question that comprises the composite. A response of "Yes" is considered positive for the questions comprising the four *Counseling and Screening* composites, the *Private and Confidential Care* composite, and the *Health Information* composite. Responses of "Usually" or "Always" are considered positive for the *Communication and Experience of Care* composite and "Very Helpful" or "Helpful" are considered positive for the *Helpfulness of Counseling* composite. Health Plan scores are compared to the overall program score in 2006 and a benchmark. The benchmark is based on the highest score achieved by a health plan.

The survey questions that comprise each composite score are listed below.

Counseling and Screening to Prevent Risky Behavior

- Talked with doctor about using a helmet when riding a bicycle, rollerblading or skateboarding
- Talked with doctor about riding in a motor vehicle with a driver who has been drinking or using drugs
- Talked with doctor about violence prevention
- Talked with doctor about guns and other weapons
- Talked with doctor about chewing tobacco or snuff
- Talked with doctor about drug use
- Talked with doctor about use of steroids without a doctor's prescription
- Talked with doctor about sexual or physical abuse
- Talked with doctor about cigarettes or smoking
- Talked with doctor about how and why to quit smoking
- Talked with doctor about alcohol use
- Talked with doctor about the importance of wearing a seat belt

Counseling and Screening to Prevent Unwanted Pregnancy and STDs

- Talked with doctor about sexually transmitted diseases
- Talked with doctor about condoms
- Talked with doctor about birth control

Counseling and Screening Related to Diet, Weight and Exercise

- Talked with doctor about weight
- Talked with doctor about healthy eating or diet
- Talked with doctor about physical activity or exercise

Counseling and Screening Related to Depression, Mental Health and Relationships

- Talked with doctor about friends
- Talked with doctor about school performance or grades
- Talked with doctor about emotions or moods

- Talked with doctor about suicide
- Talked with doctor about sexual orientation
- Talked with doctor about feeling sad or hopeless almost every day

Care Provided in a Confidential and Private Setting

- Had a chance to speak with a doctor or other health provider privately
- Told that what was talked about with doctor was confidential

Helpfulness of Counseling Provided

- Very helpful or helpful discussions in understanding the risks of cigarettes or smoking to your health
- Very helpful or helpful discussions in quitting smoking
- Very helpful or helpful discussions in understanding alcohol use and its risk to your health
- Very helpful or helpful discussions in understanding how to use condoms to prevent HIV and other STDs
- Very helpful or helpful discussion in understanding how and why to use birth control

Communication and Experience of Care

- Office staff usually or always helpful
- Doctors usually or always listened carefully
- Never or sometimes had a hard time speaking with or understanding doctor because he or she spoke different languages.
- Doctor usually or always explained things in an understandable way
- Doctor usually or always spent enough time with you
- Positive rating of all care

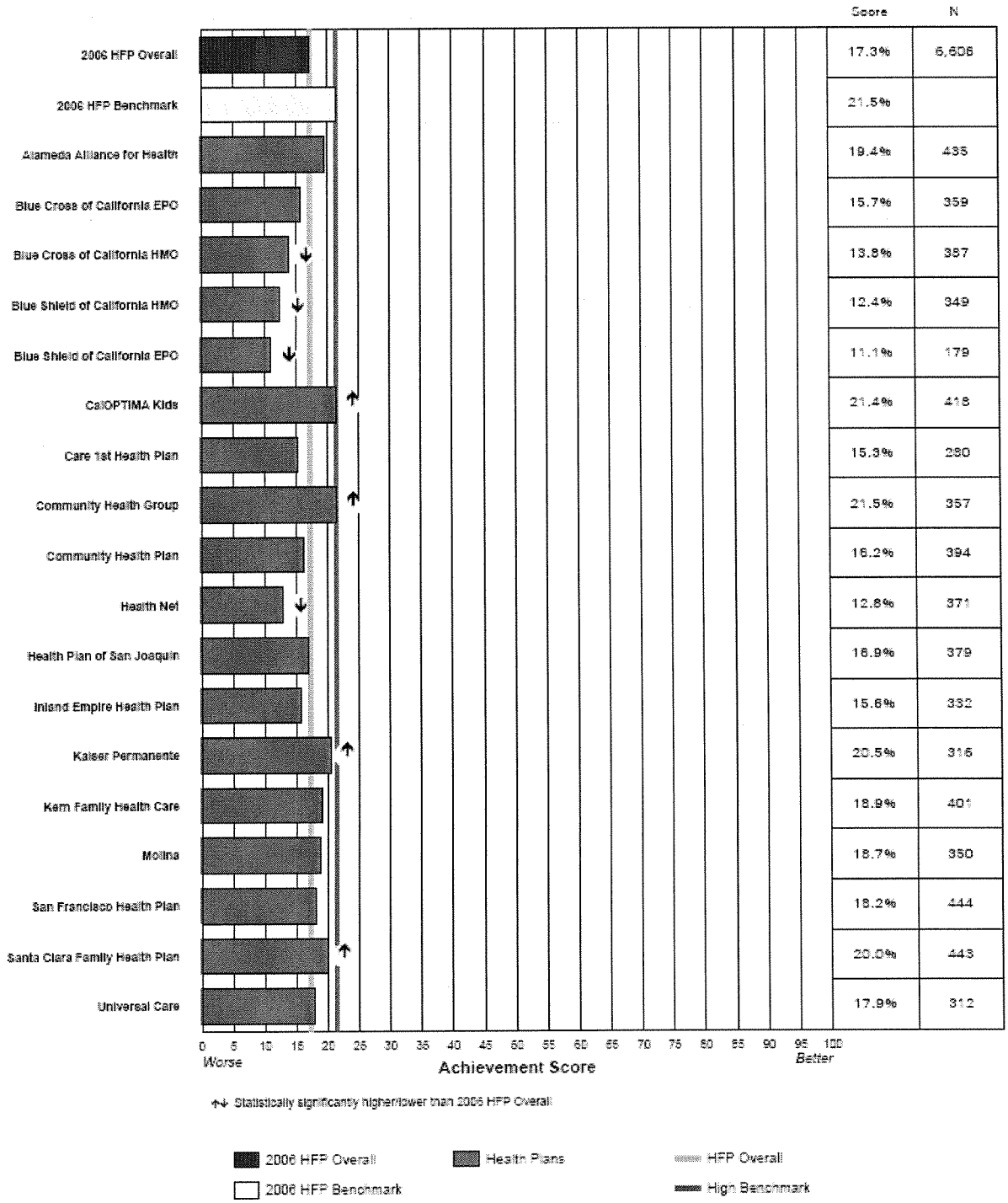
Health Information

- Saw or heard information that provided safety tips
- Saw or heard information about the risks of smoking, drinking or other substance abuse
- Saw or heard information about the benefits of a healthy diet, physical activity or exercise
- Saw or heard information that provided tips about how to prevent sexually transmitted diseases.

The following pages contain the HFP overall program scores and the individual plan results for the composite scores. Plans that have achievement scores significantly higher or lower than the overall program score are indicated by a "↑" or "↓" next to their scores.

Counseling and screening to prevent risky behavior

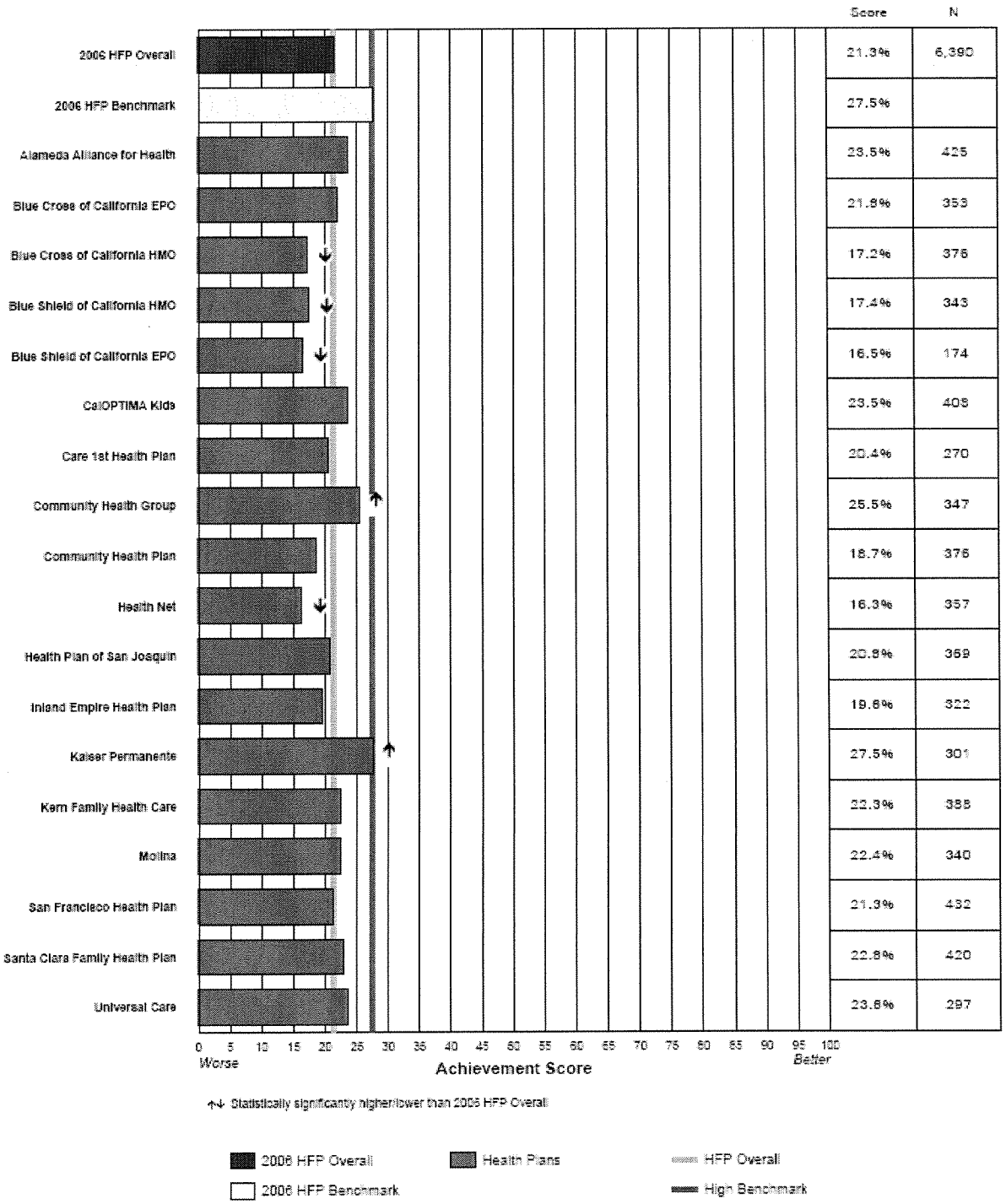
Composite Score



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Counseling and screening to prevent unwanted pregnancy and STDs

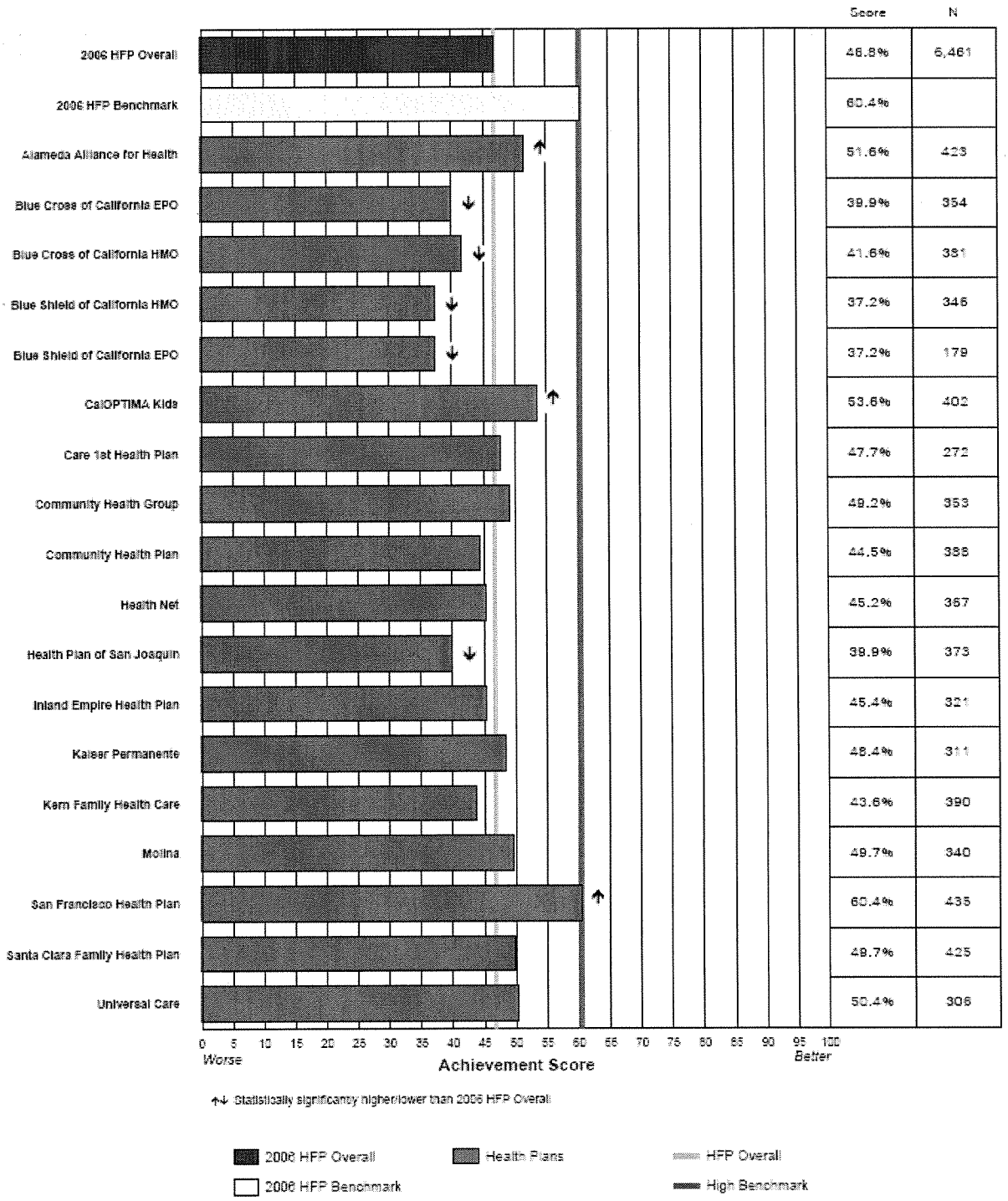
Composite Score



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Counseling and screening related to diet, weight and exercise

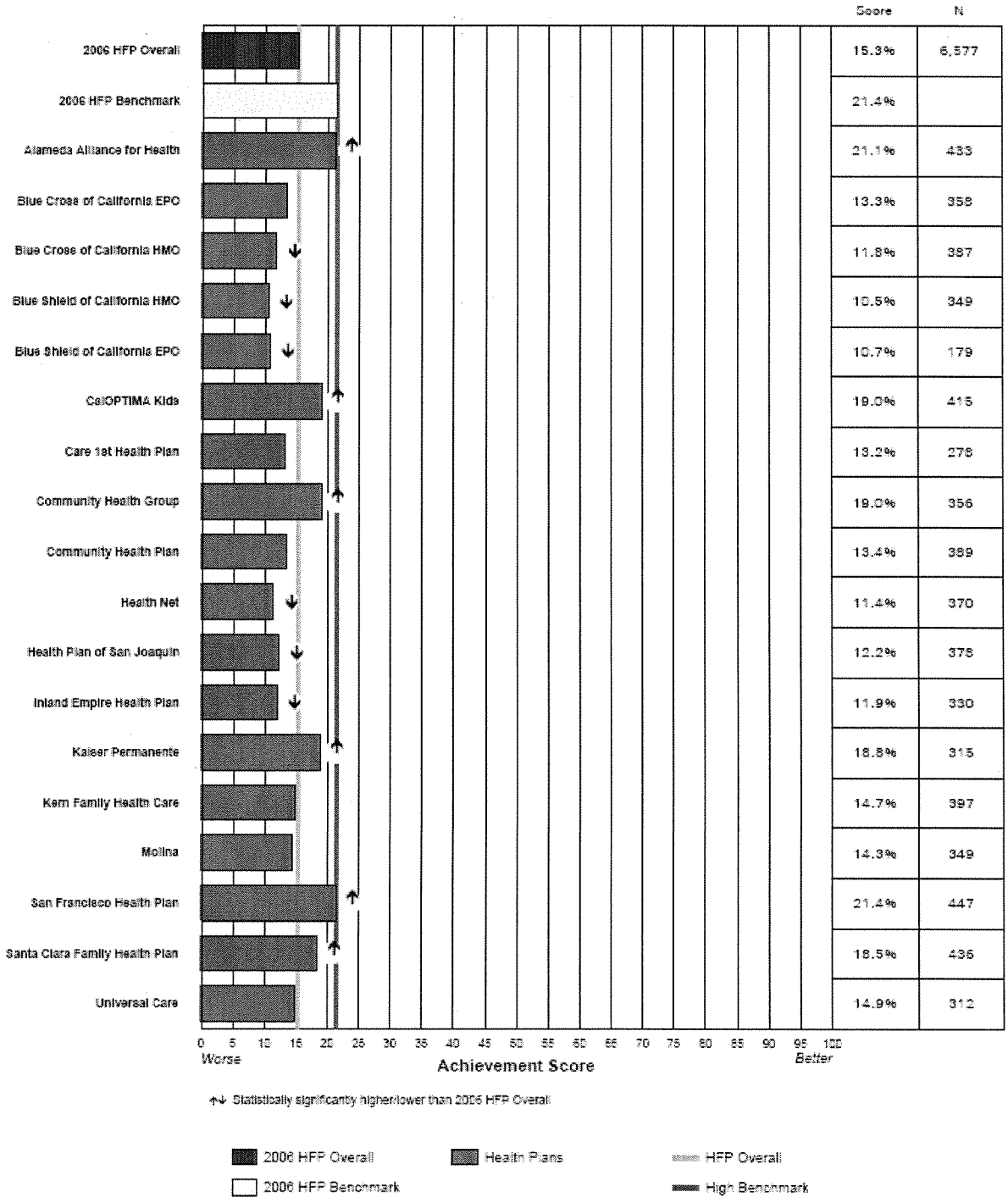
Composite Score



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

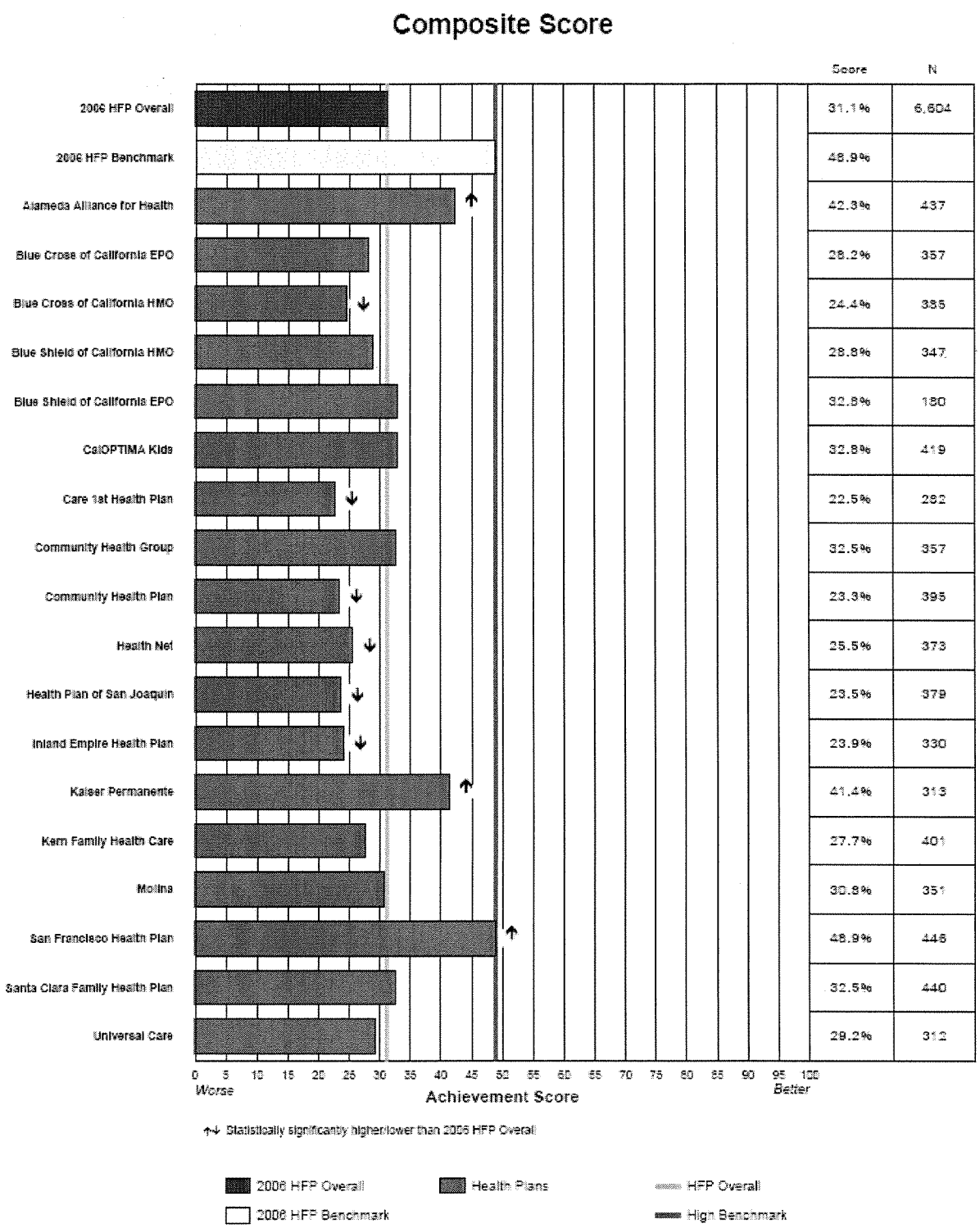
Counseling and screening related to depression, mental health, and relationships

Composite Score



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

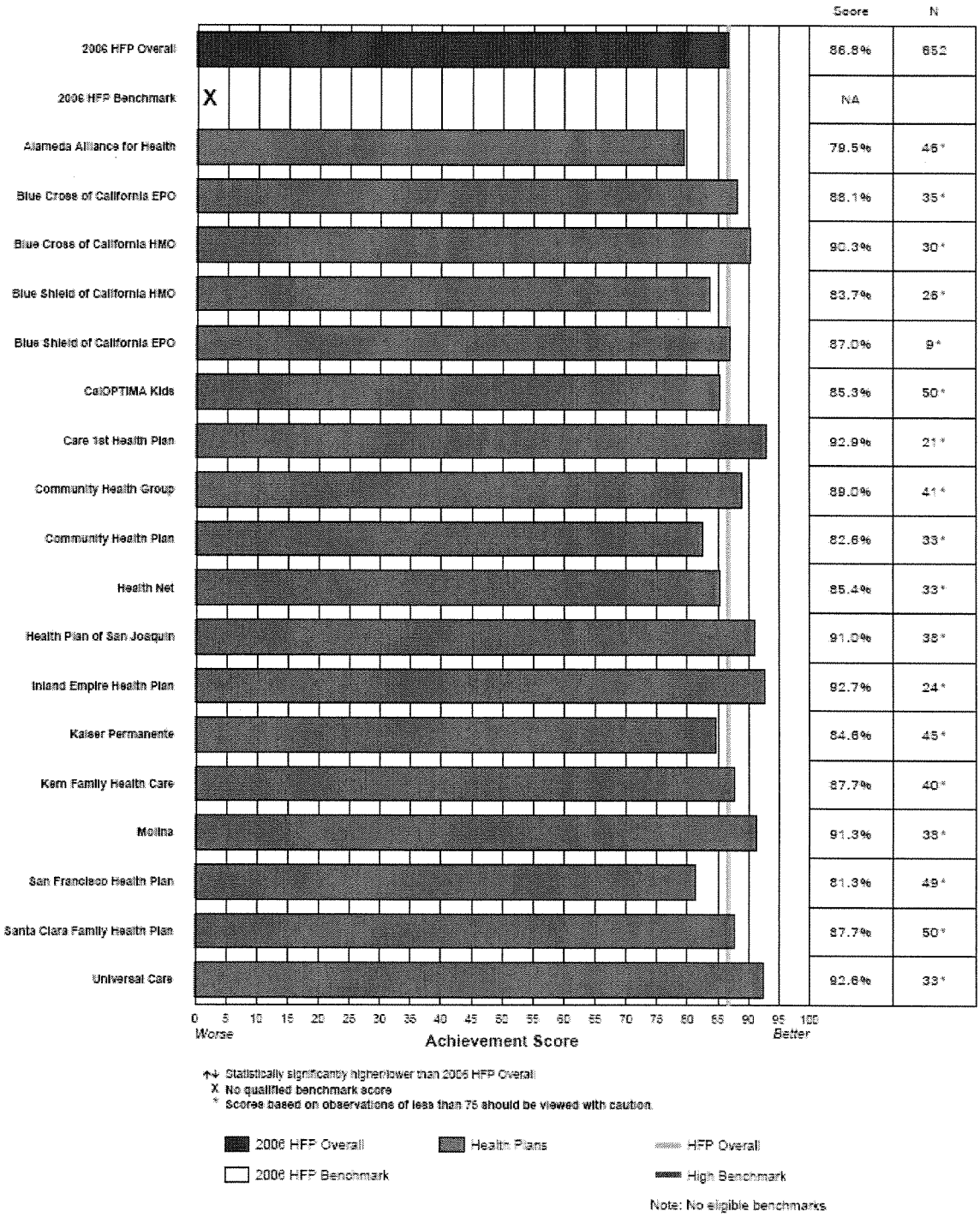
Care provided in a confidential and private setting



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Helpfulness of counseling provided

Composite Score

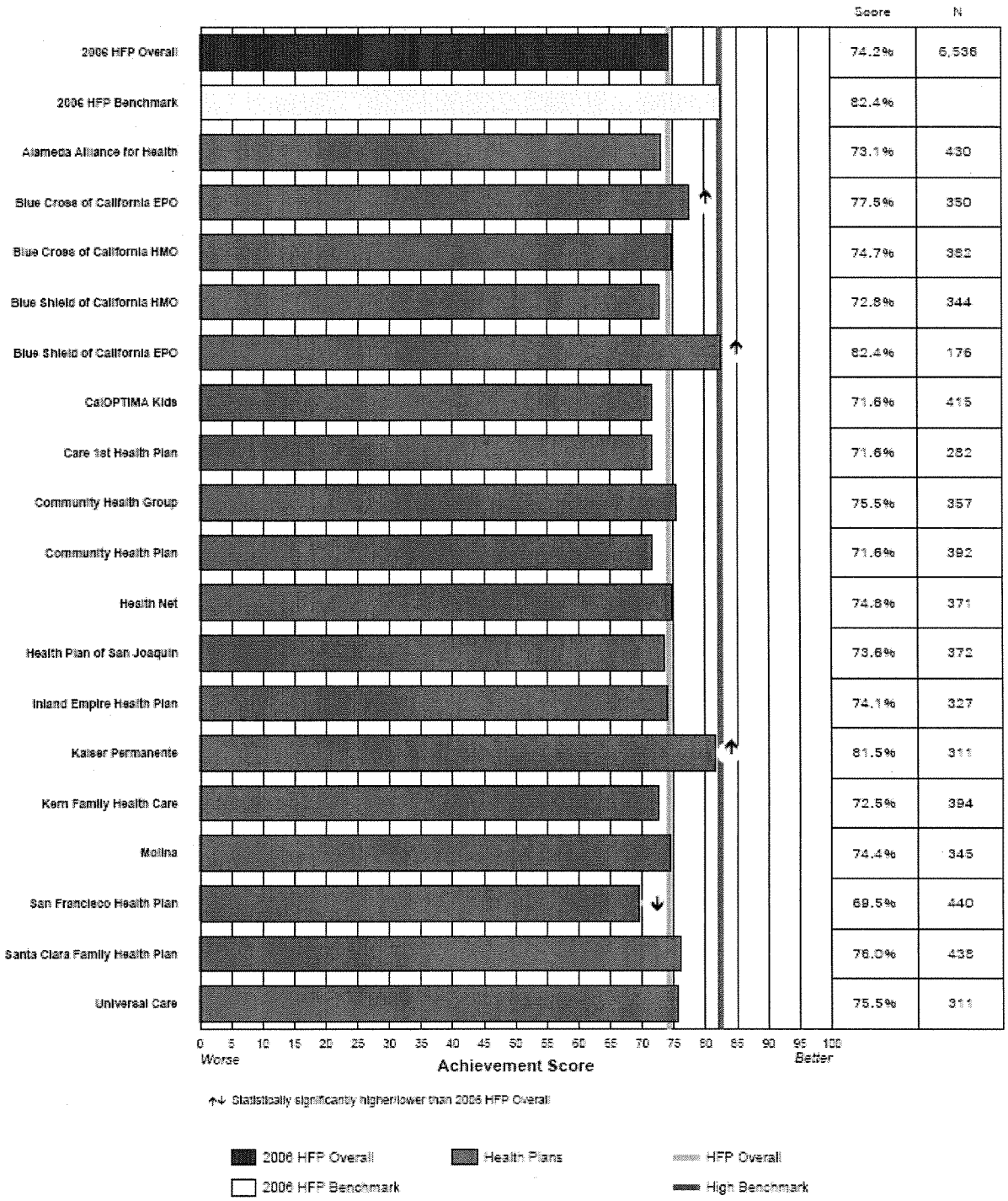


Note: A minimum of 75 responses is required to qualify as a benchmark. For the *Helpfulness of Counseling Provided* composite, there were no plans that had 75 or more respondents.

Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Communication and experience of care

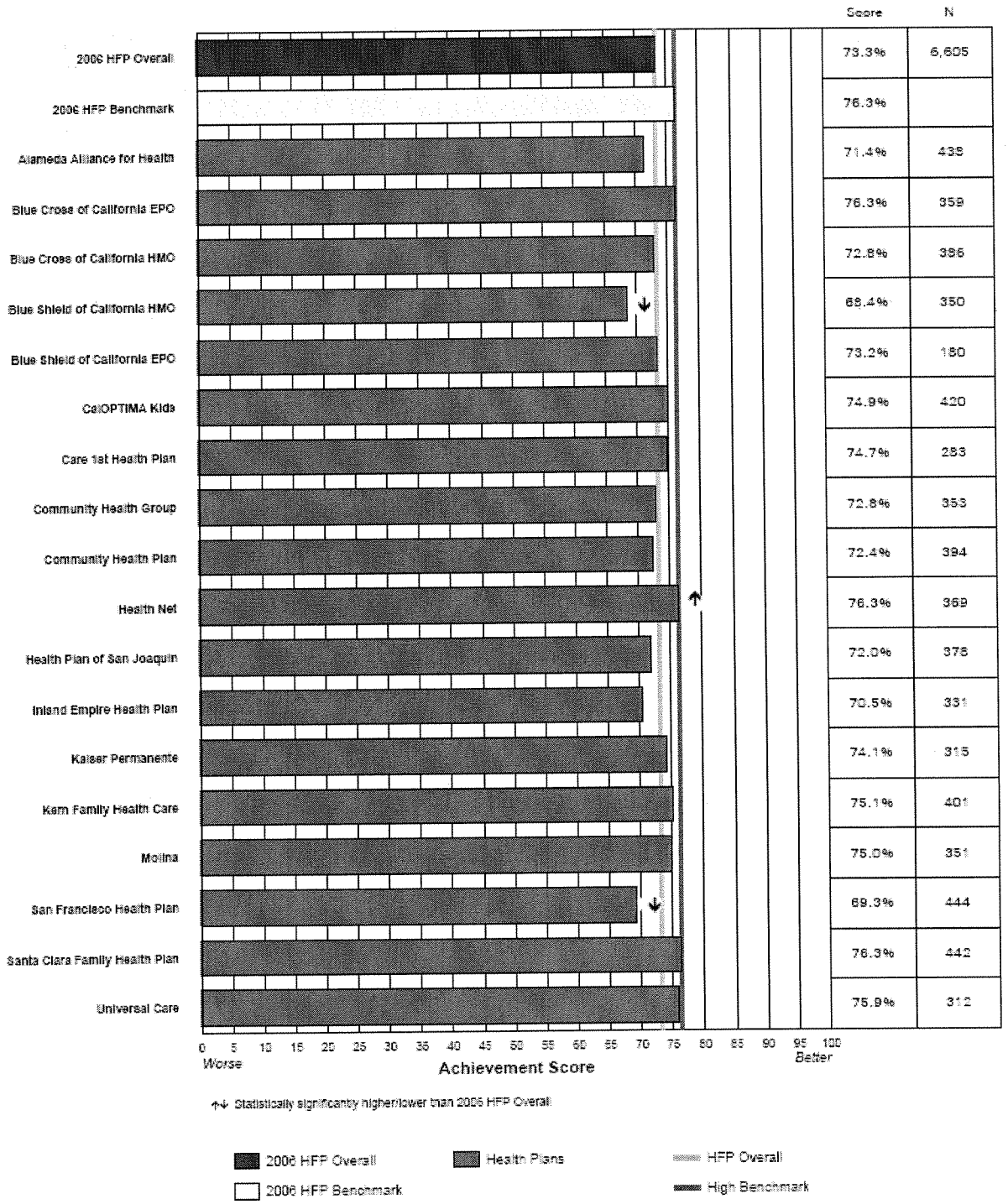
Composite Score



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Health information

Composite Score



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Summary of Composite Score Results:

The following plans had achievement scores that were significantly above the program average in three or more domains:

- Kaiser Permanente achieved above average scores in five of the seven domains.
- Alameda Alliance for Health, CalOPTIMA Kids, Community Health Group, and San Francisco Health Plan achieved above average scores in three of the seven domains.

The following plans had achievement scores that were significantly below the program average in three or more domains:

- Blue Cross HMO and Blue Shield HMO received below average scores in five of the seven domains.
- Blue Shield EPO and Health Net received below average scores in four of the seven domains.
- Health Plan of San Joaquin received below average scores in three of the seven domains.

Table 5 on the following page shows whether the plan results for the composite scores were statistically significantly above or below the program average score for 2006. The *Helpfulness of Counseling Provided* composite is not included in Table 5 because no plans had 75 or more respondents and therefore a statistically significant comparison to the HFP overall score could not be made.

Table 5 – Statistically Significantly Higher and Lower than HFP Composite Scores

Health Plan	Counseling and Screening to Prevent Risky Behavior	Counseling and Screening to Prevent Unwanted Pregnancy and STD's	Counseling and Screening Related to Diet, Weight and Exercise	Counseling and Screening Related to Depression, Mental Health and Relationships	Care Provided in a Confidential and Private Setting	Communi-cation and Experience of Care	Health Information
Alameda Alliance for Health			▲	▲	▲		
Blue Cross EPO			▼			▲	
Blue Cross HMO	▼	▼	▼	▼	▼		
Blue Shield HMO	▼	▼	▼	▼			▼
Blue Shield EPO	▼	▼	▼	▼		▲	
CalOPTIMA Kids	▲		▲	▲			
Care 1st Health Plan					▼		
Community Health Group	▲	▲		▲			
Community Health Plan					▼		
Health Net	▼	▼		▼	▼		▲
Health Plan of San Joaquin			▼	▼	▼		
Inland Empire				▼	▼		
Kaiser	▲	▲		▲	▲	▲	
Kern Family Health Care							
Molina							
San Francisco			▲	▲	▲	▼	▼
Santa Clara Family Health	▲			▲			
Universal Care							

**Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey*

▲ = Statistically significantly higher than HFP Overall Composite Score

▼ = Statistically significantly lower than HFP Overall Composite Score

SURVEY RESULTS: SINGLE ITEM RATINGS

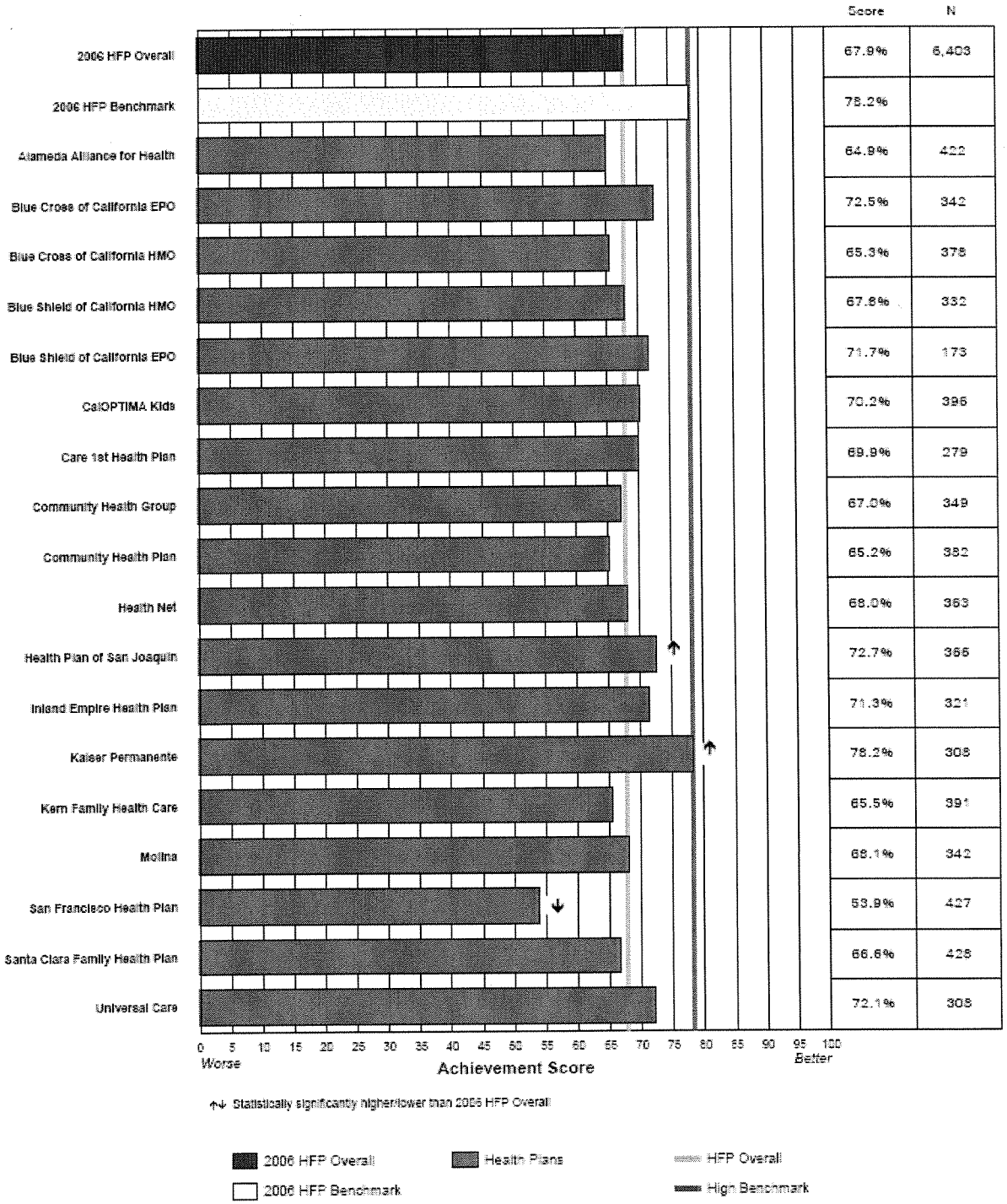
The achievement score for single item scores is determined by the percentage of teens who respond positively to each question. The survey questions that comprise the single item ratings are listed below:

- *In the last 12 months, how much of a problem, if any, was it to get the care you or a doctor or other health provider believed necessary?* A response of "not a problem" is considered positive.
- *In the last 12 months, have you ever had a serious health problem that went untreated?* A response of "no" is considered positive.
- *How is your health in general?* A response of "excellent" or "very good" is considered positive.

The following pages contain the HFP overall scores and the individual plan results for the single item ratings. Plans that have achievement scores significantly higher or lower than the overall program score are indicated by a "↑" or "↓" next to their scores.

Single Items

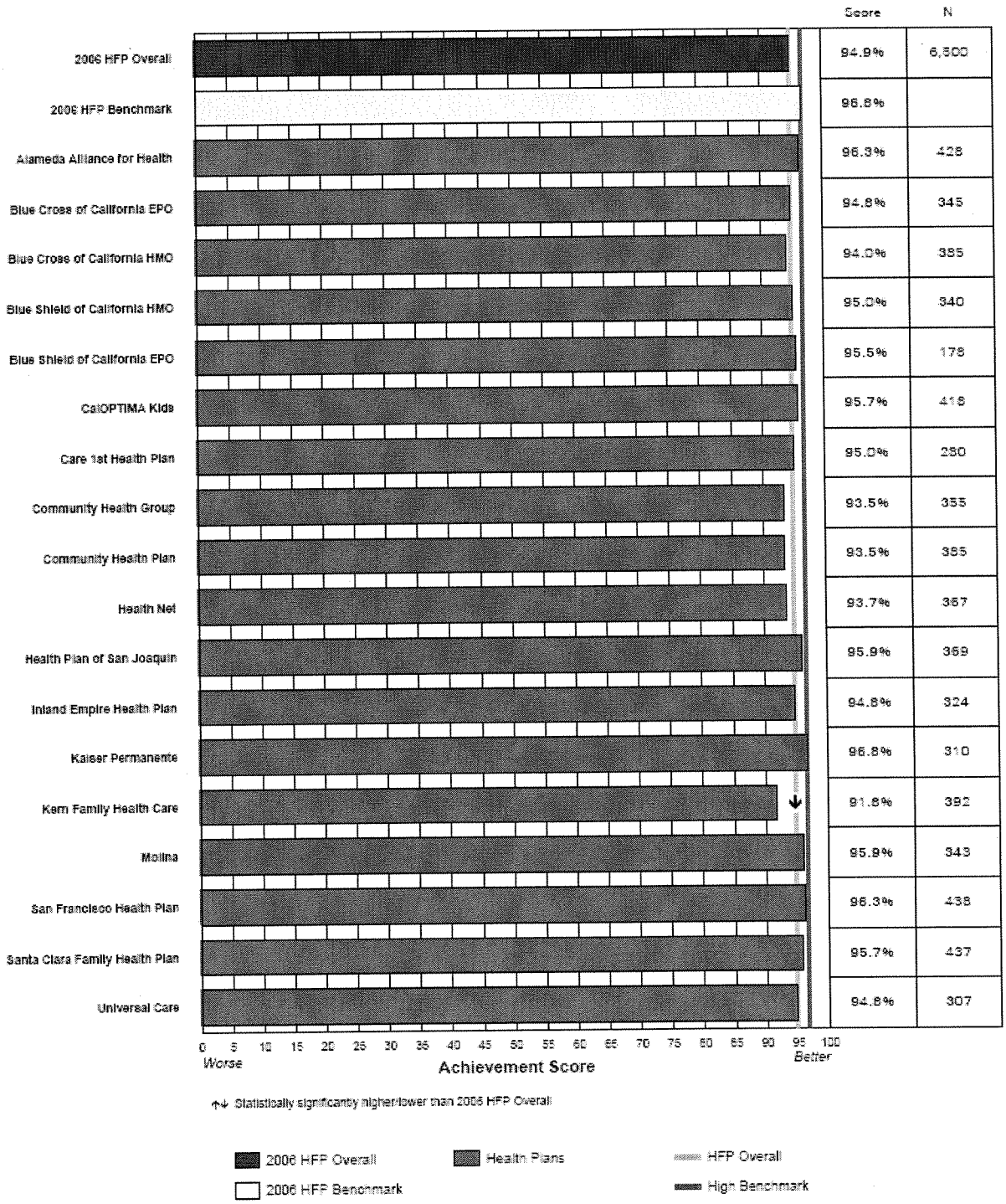
Q44. Not a problem to get care you or a doctor believed necessary



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Single Items

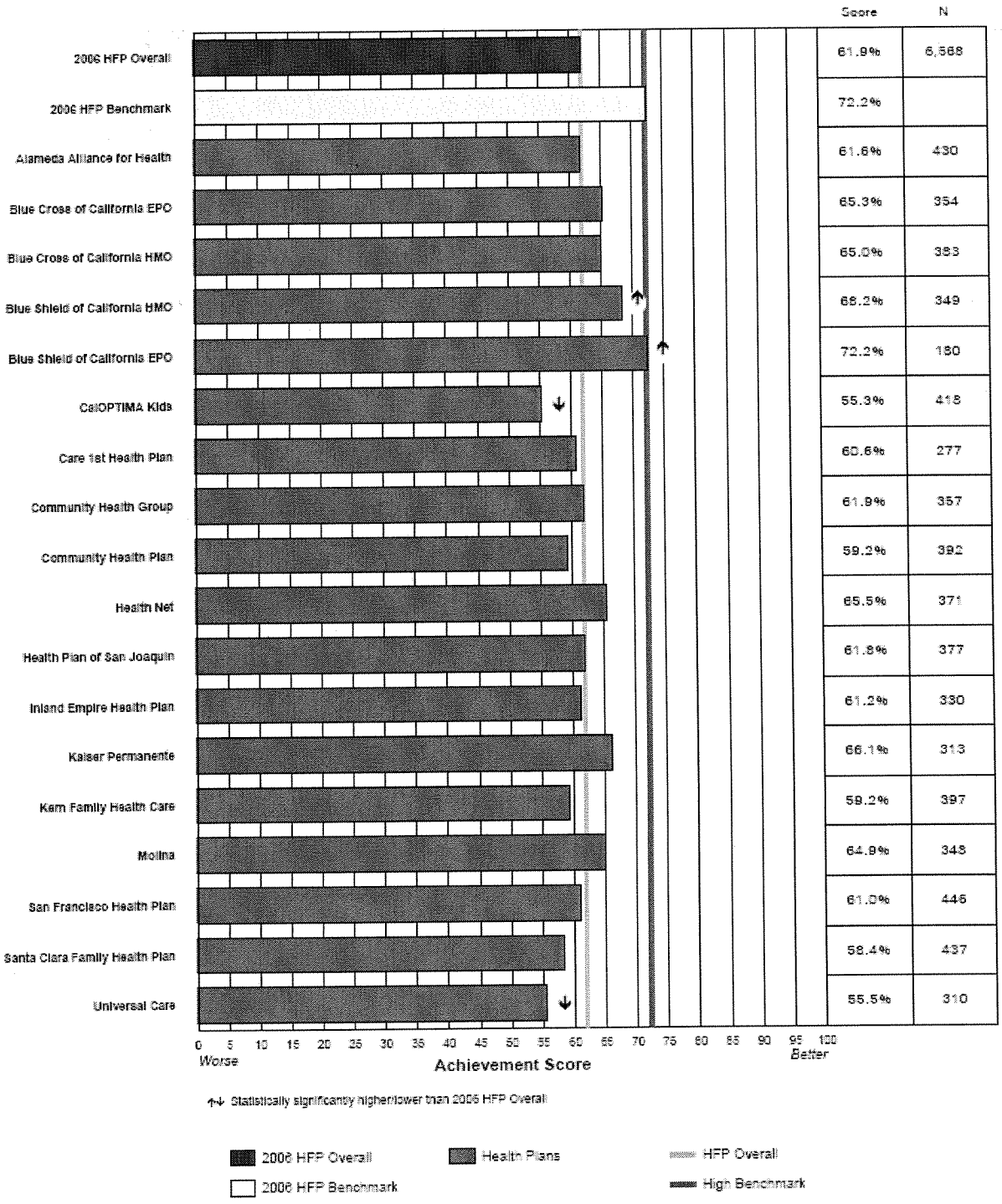
Q45. Did not have a serious health problem that went untreated



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Single Items

Q47. Excellent or very good rating of health status



Note: Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey

Summary of Single Item Rating Question Responses

The following plans had achievement scores that were significantly above the program average on one of the three questions:

- Blue Shield EPO
- Blue Shield HMO
- Health Plan of San Joaquin
- Kaiser Permanente

The following plans had achievement scores that were significantly below the program average on one of the three questions:

- CalOPTIMA Kids
- Kern Family Health Care
- San Francisco Health Plan
- Universal Care

Table 6 shows whether the plan results for the single item rating questions were statistically significantly above or below the program average score for 2006.

Table 6 – Statistically Significantly Higher and Lower than HFP Overall Ratings Scores

Health Plan	Not a Problem to Get Care You or Your Doctor Believed Necessary	Did Not Have a Serious Health Problem that Went Untreated	Excellent or Very Good Rating of Health Status
Alameda Alliance for Health			
Blue Cross EPO			
Blue Cross HMO			
Blue Shield HMO			▲
Blue Shield EPO			▲
CalOPTIMA Kids			▼
Care 1st Health Plan			
Community Health Group			
Community Health Plan			
Health Net			
Health Plan of San Joaquin	▲		
Inland Empire			
Kaiser	▲		
Kern Family Health Care		▼	
Molina			
San Francisco	▼		
Santa Clara Family Health			
Universal Care			▼

**Universal Care is no longer participating in the Healthy Families Program but was included in the 2006 survey*

▲ = Statistically significantly higher than HFP Overall Rating Scores

▼ = Statistically significantly lower than HFP Overall Rating Scores

SURVEY RESULTS: COMPARISON TO CAHMI

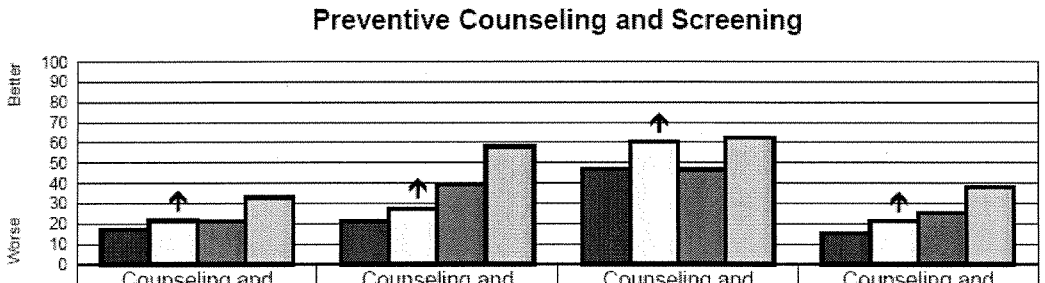
The YAHCS survey was developed and tested nationally by the Child and Adolescent Health Measurement Initiative (CAHMI). The CAHMI was established in 1998 by The Foundation for Accountability (FACCT) and The National Committee on Quality Assurance (NCQA). It provides leadership and resources for measuring and communicating information about the quality of health care for children and adolescents. Over 70 consumer organizations, policymakers, researchers, health care practitioners, health plans and health care purchasers have participated in the CAHMI since May, 1998.

This is the first year that the HFP has used the YAHCS. Therefore, there is no current trend data available for comparison. The results of the HFP survey can be compared to the CAHMI benchmark database. The CAHMI benchmark database represents 2,561 young adults enrolled in Medicaid and/or SCHIP in California, Florida, New York and Washington who were surveyed between 1999 and 2002.

Table 7 compares the HFP overall score to the HFP benchmark and to both the CAHMI overall score and the CAHMI benchmark for the four YAHCS quality measures that look at preventive screening and counseling administered to teens. These four measures address the following topics:

- risky behaviors
- sexual activities and STD's
- weight, healthy diet and exercise
- depression, emotional health and relationship issues

Table 7 – Preventive Counseling and Screening

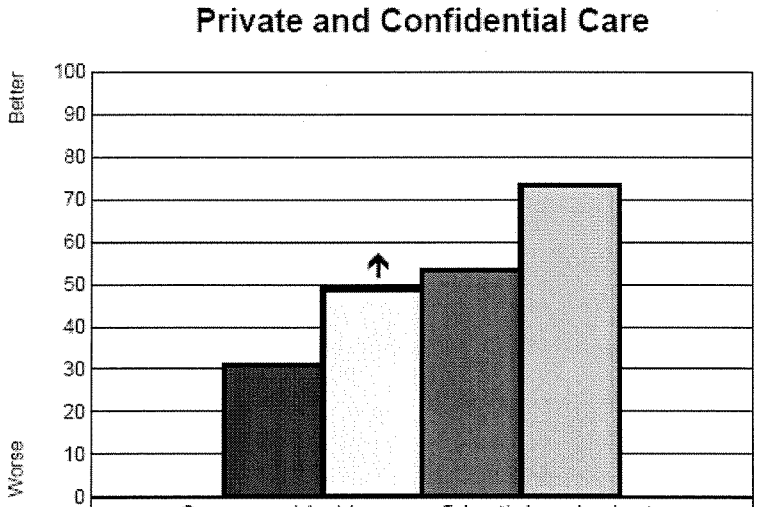


	Counseling and screening to prevent risky behavior	Counseling and screening to prevent unwanted pregnancy and STDs	Counseling and screening related to diet, weight and exercise	Counseling and screening related to depression, mental health, and relationships
HFP Overall	17.3%	21.3%	46.8%	15.3%
HFP Benchmark	21.5%	27.5%	60.4%	21.4%
CAHMI Overall	21.0%	39.5%	46.5%	25.3%
CAHMI Benchmark	33.0%	58.1%	62.1%	38.0%

↑↓ Statistically significantly better/worse than HFP Overall

The American Medical Association (AMA) Guidelines on Adolescent Preventive Services recommend yearly screening of teens in a private and confidential health care setting. Table 8 compares the HFP overall score to the HFP benchmark and to both the CAHMI overall score and the CAHMI benchmark for *Private and Confidential Care* measure.

Table 8 – Private and Confidential Care



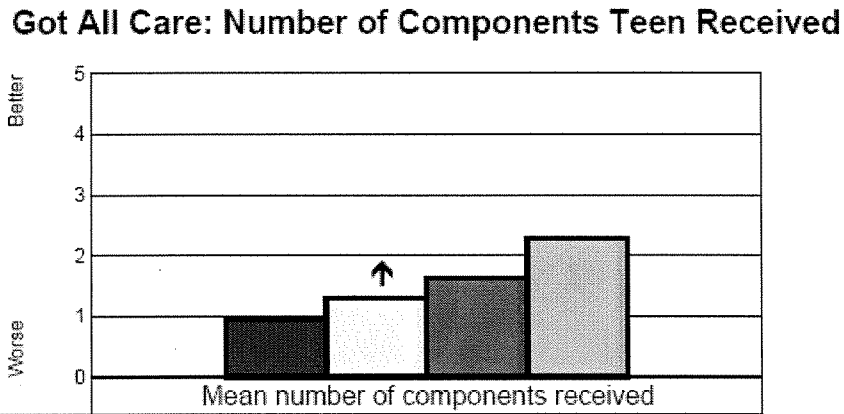
	Care provided in a confidential and private setting
HFP Overall	31.1%
HFP Benchmark	48.9%
CAHMI Overall	53.3%
CAHMI Benchmark	73.3%

↑↓ Statistically significantly better/worse than HFP Overall

Table 9 shows the mean number of components of care the teen received based on 5 measurements of care and the thresholds of care established by CAHMI. The HFP overall score is compared to the HFP benchmark score and to both the CAHMI overall score and the CAHMI benchmark for the *Got All Care* measures. The 5 measurements of care and the recommended threshold are as follows:

- Counseling and screening to prevent risky behavior. Teen must be screened for 50% of the topics.
- Counseling and screening to prevent unwanted pregnancies and STDs. Teen must be screened for 67% of the topics.
- Counseling and screening related to diet, weight and exercise. Teen must be screened for 67% of the topics.
- Counseling and screening related to depression and mental health. Teen must be screened for 50% of the topics.
- Care provided in a private and confidential setting. Teen must receive care in both a private and confidential setting.

Table 9 – Got All Care: Number of Components Teen Received



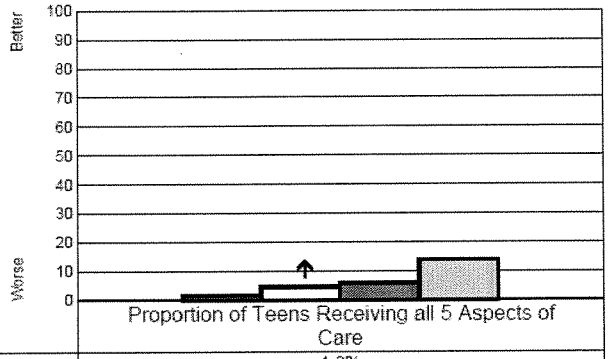
	Mean number of components received
HFP Overall	0.95
HFP Benchmark	1.31
CAHMI Overall	1.63
CAHMI Benchmark	2.29

↑↓ Statistically significantly better/worse than HFP Overall

Table 10 shows the proportion of teens that received all five measurements of care listed above and compares the HFP overall score to the HFP benchmark score and to both the CAHMI overall score and the CAHMI benchmark for the *Got All Care* measures.

Table 10 – Got All Care: Proportion of Teens Who Got All 5 Aspects of Care

Got All Care: Proportion of Teens Who Got All 5 Aspects of Care



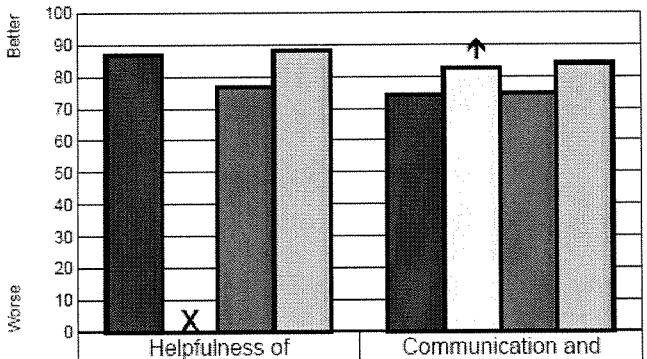
	Proportion of Teens Receiving all 5 Aspects of Care
HFP Overall	1.8%
HFP Benchmark	4.5%
CAHMI Overall	5.8%
CAHMI Benchmark	14.0%

↑↓ Statistically significantly better/worse than HFP Overall

Table 11 compares the HFP overall score to the HFP benchmark score and to both the CAHMI overall score and the CAHMI benchmark for the *Helpfulness of Counseling Experience of Care* composites.

Table 11 – Helpfulness of Counseling and Experience of Care Composites

Helpfulness of Counseling and Experience of Care Composites



	Helpfulness of counseling provided	Communication and experience of care
HFP Overall	86.8%	74.2%
HFP Benchmark	-	82.4%
CAHMI Overall	76.7%	74.6%
CAHMI Benchmark	88.2%	84.0%

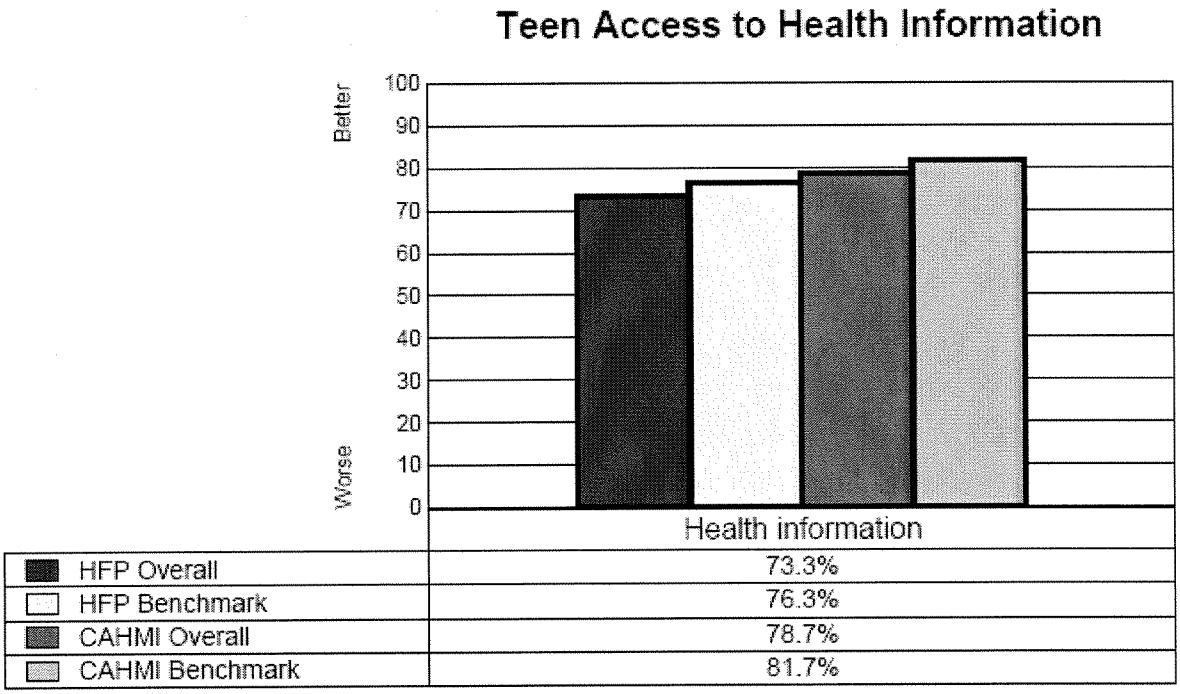
↑↓ Statistically significantly better/worse than HFP Overall

X No qualified benchmark score

Note: A minimum of 75 responses is required to qualify as a benchmark. For the *Helpfulness of Counseling Provided* composite there were no plans that had 75 or more respondents.

Table 12 compares the HFP overall score to the HFP benchmark score and to both the CAHMI overall score and the CAHMI benchmark for the *Teen Access to Health Information* measure.

Table 12 – Teen Access to Health Information



	Health information
HFP Overall	73.3%
HFP Benchmark	76.3%
CAHMI Overall	78.7%
CAHMI Benchmark	81.7%

CONCLUSION

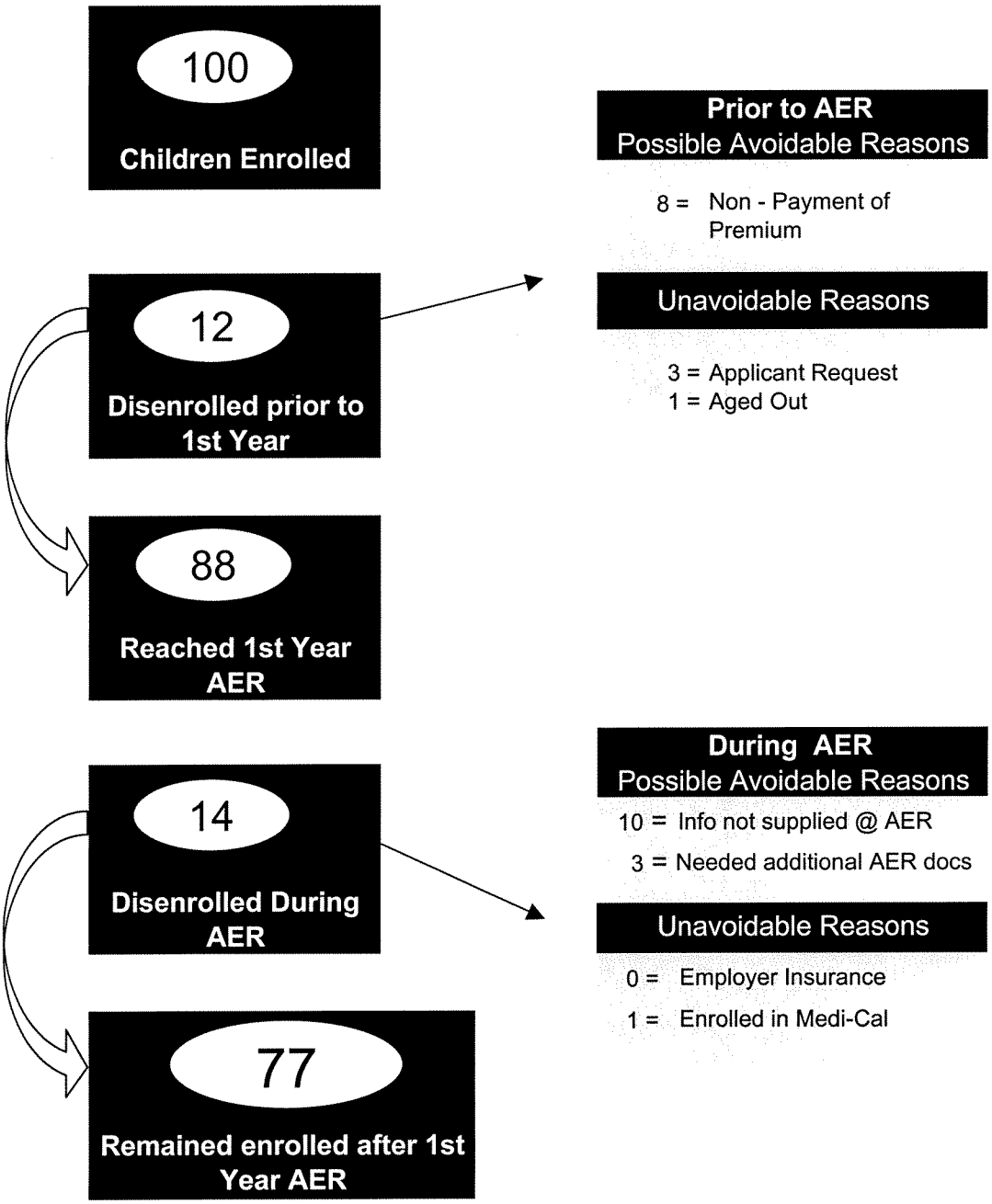
The data obtained from this report provides the plans and MRMIB with an opportunity to further evaluate best practices as well as areas needing improvement. The results of this report provide the framework for discussion on how the HFP can better support and educate teens as well as addressing important factors such as teen mental health, physical activity and risky behavior. MRMIB will be meeting with the plans to discuss quality improvement activities for deficient areas and for sharing best practices among participating health plans. In addition, the survey results will be used in conjunction with other quality measurement tools to assess plan performance.

Acknowledgements
Prepared by Mary Watanabe, Benefits Specialist
Assisted by Cristal Schoenfelder, Policy and Operations Manager, Benefits and Quality Monitoring Division

ATTACHMENT V:

HEALTHY FAMILIES PROGRAM 2005 ANNUAL RETENTION REPORT

Retention and Disenrollment
Enrolled May 2004 to April 2005
N = 195,550



Retention and Disenrollment
Enrolled May 2004 to April 2005
N = 195,550

Breakdown of Families Disenrolling after 1 Year

% of Families Disenrolled after 1 Year	26%

Because of .....

Unavoidable Reasons		
Employer Insurance	0%	
Enrolled in Medi-Cal	1%	5%
Aged Out	1%	
Applicant's Request	3%	

And .....

Possibly Avoidable Reasons		
Info not supplied @ AER	10%	21%
Needed additional AER Docs	3%	
Non Payment of Premiums	8%	

Of the Possibly Avoidable Reasons .....

NASHP Retention Study of 2001 indicated that **60%** of families determined that they were ineligible and failed to inform S-CHIP programs of new coverage or status of change.

21% X .6 = 13%

Which leaves those not accounted for .....

Possibly Avoidable Reasons	_ 19%	6%
Explained by NASHP Study	13%	

ATTACHMENT VI:

HEALTHY FAMILIES PROGRAM HEALTH STATUS ASSESSMENT (PEDSQL™) 2004

The Healthy Families Program
Health Status Assessment (PedsQL™) Final Report

Revised September 2004

Managed Risk Medical Insurance Board

EXECUTIVE SUMMARY

The most significant achievement of the Healthy Families Program (HFP), California's State Children's Health Insurance Program (SCHIP), has been to increase access to medical services for children enrolled in the program. While it is reasonable to presume that improved access to care would affect the health status of children in a positive manner, only through a special project has MRMIB been able to document the connection between access to care and positive changes in health status. MRMIB implemented a longitudinal survey of families of children who were newly enrolled in the HFP in 2001 to measure changes in access to care and health status among these children over two years of enrollment.

Results from this project showed:

- Dramatic, sustained improvements in health status for the children in the poorest health and significant, sustained increases for these children is paying attention in class and keeping up in school activities.
- Meaningful improvement in health status for the population at large.
- Increased access to care and reduced foregone health care for children in the poorest health and the population at large.
- A lack of significant variation by race and language in reports of no foregone care--the most significant variable associated with access.

The most significant improvements occurred after one year of enrollment in the program. These gains were sustained through the second year of enrollment. Because the survey does not quantify all factors that are attributable to changes in health status, it is not known how much of an impact changes in access to care has on the overall changes seen in health status. It is also not known what the underlying health status is of the children participating in this survey. Therefore, the strongest conclusion and/or correlation that can be made regarding these results is that the HFP contributes to the improvements in health status by increasing access to health care services.

This report describes the project in detail and presents specific findings from the project.

BACKGROUND

MRMIB conducted this project to fulfill a legislative mandate to report changes in health status among children enrolled in the Healthy Families

Program.[1] To measure changes in health status, MRMIB followed newly enrolled children over a two-year period. At the recommendation of the HFP Quality Improvement Work Group, MRMIB selected the Pediatric Quality of Life Inventory™ or PedsQL™ as the instrument to use to assess the health status of the children. The PedsQL™ is a short questionnaire, consisting of 23 questions that address physical and psychosocial aspects of health. The questionnaire was selected because of its brevity, ease in completion, and use in broad age groups (ages 2 through 18). The developers of the PedsQL™ questionnaire have also used the questionnaire in Medicaid and commercial populations in California. Research has shown that self-assessment is an acceptable method for measuring health status among populations.[2,3,4] Prior research on the PedsQL™ has demonstrated a consistent difference in health status scores between healthy children and children with chronic health conditions such as asthma, arthritis, cancer and diabetes. Healthy children have been shown to have significantly higher scores than children with clinically diagnosed chronic conditions[5].

The Survey Process

The survey was conducted by mailing the PedsQL™ to the families of approximately 20,000 HFP children who were newly enrolled in the program during the months of February and March 2001. Questionnaires were mailed to families during their first month of enrollment. Families received the survey in either English, Spanish, Vietnamese, Korean, or Chinese based on the primary language indicated on each family's HFP application. Each family received prior notification of the questionnaire during a welcome call they received from the HFP administrative vendor. In addition to the pre-notification call and the initial questionnaire, reminder post cards and a second questionnaire were mailed to non-responders. If the questionnaire was not returned after the second mailing, a follow-up call was made. Families who remained on the program as of February and March 2002 (6,881) and February and March 2003 (4,952) were sent a second and third survey. For each family, one child in the household was selected as the subject for the survey; a parent and the subject (if 5 years or older) were each given a questionnaire to complete.

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[1] California Insurance Code, Section 12693.92

[2]McHorney CA, Ware JE, Raczek AE. The MOS 36-item short-form health survey (SF-36): II. Psychometric and clinical tests of validity in measuring physical and mental health constructs. Medical Care 1993;31(3):247-263.

[3] McHorney CA, Ware JE, Jr., Lu JF, Sherbourne CD. The MOS 36-item Short-Form Health Survey (SF-36): III. Tests of data quality, scaling assumptions, and reliability across diverse patient groups. Medical Care 1994;32(1):40-66.

[4] Eisen M, Donald CA, Ware JE, Brook RH. Conceptualization and measurement of health for children in the health insurance study. Santa Monica, CA: RAND; 1980.

[5] Varni, J.W., Seid, M., Kurtin, P.S.; Peds QL™ 4.0: Reliability and validity of the Pediatric Quality of Life Inventory Version 4.0--Generic Core Scales in healthy and patient populations. Medical Care 39(8) 800-812.

The PedsQL™ Questionnaire

The PedsQL™ Questionnaire contains 23 core questions that address the physical and psychosocial aspects of health. With respect to the psychosocial aspect of health, the questionnaire examines social, emotional, and school functioning. For each aspect of health, survey participants are asked to rate how much of a problem five to eight "items" have been in the past 30 days.

The questionnaire varies slightly among four age groups to ensure that items asked are developmentally appropriate. The questionnaire is administered to young children (ages 5 to 7), children (ages 8 to 12) and adolescents (ages 13 to 18). The questionnaire is also administered to parents of children ages 2 to 4 years (toddlers), young children (ages 5 to 7), children (ages 8 to 12) and adolescents (ages 13 to 18).

The questionnaire asks survey participants to respond using a 5-point scale indicating how much of a problem each item has been during the past month. The scale is designed so that 0 is never a problem, 1 is almost never a problem; 2 is sometimes a problem; 3 is often a problem and 4 is almost always a problem. For very young children (ages 5 to 7 years) the numerical scale is replaced with a scale of smiley faces. Parents are asked to assist their very young children (ages 5 to 7) in completing the questionnaire by having the child assign a smiley face. A copy if the questionnaire is included in Exhibit A.

The PedsQL™ Questionnaire was supplemented for use in the Healthy Families Program by including 13 additional questions regarding access to care and chronic illness. Access related items included: the presence of a personal physician, foregone health care, and problems getting care. These additional questions were included to assess changes in access to care.

The additional survey items were adapted from the PedsQL™ Family Information Form[6], the Consumer Assessment of Health Plans Study (CAHPS™)[7] (a measure of health plan performance from the consumer's perspective), and a study examining foregone care among adolescents[8].

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[6] Varni JW, Seid M, Kurtin PS. PedsQL 4.0: Reliability and Validity of the Pediatric Quality of Life Inventory Version 4.0 Generic Core Scales in Healthy and Patient Populations. *Medical Care.* 2001;39(8):800-812.

[7] Hays RD, Shaul JA, Williams VS, et al. Psychometric properties of the CAHPS 1.0 survey measures. Consumer Assessment of Health Plans Study. *Medical Care.* 1999;37(3 Suppl):MS22-31.

[8] Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *JAMA* 1999;282(23):2227-34.

Calculation of Health Status Scores

Each response received from survey participants is reverse scored and linearly transformed to a 100 point scale where 0 becomes 100 points, 1 becomes 75 points, 2 becomes 50 points, 3 becomes 25 points and 4 becomes 0 points. The higher the score, the better the health related quality of life. Three summary scores are calculated for each completed questionnaire. The Total Score (all 23 items) is computed as the mean of the item responses divided by the number of items answered in the Physical and Psychosocial sub-scales. The Physical Score is the mean of the item responses for that aspect of health. The Psychosocial Health Score is calculated by summing the item responses for the Emotional, Social and School functions scales and dividing by the number of items answered. Based on previous studies using the PedsQL, children in good health have scores around 83. Children in poor health have scores in the mid-60s to low 70s.[9]

RESULTS

Response Rates

The results of the survey are based on a significant number of surveys that had been returned by parents over the 2 years of the project. Because each year approximately 30 percent of children do not re-enroll in the program for various reasons, the total sample for 2002 and 2003 declined from 2001. At the beginning of the project, approximately 20,000 surveys were mailed to newly enrolled HFP subscribers and their caregivers. By the end of the project, survey data was available on 3,738 children who had remained enrolled in the program from 2001 through 2003 and had completed the three surveys. The researchers view the response rates for each year as quite robust and of more than adequate size on which to base conclusions. Table 1 shows the disposition of the sample from 2001 through 2003.

Table 1: Disposition of Sample from 2001 through 2003

Year of Survey	Total Sample	Total Surveys Returned	Response Rates	Number of children leaving HFP at the end of the year
2001	20,000	10,241	51.2%	3,360
2002	6,881	6,005	87.3%	1,929
2003	4,952	3,738	75.5%	----------

Over the two year period, the response rates among age, ethnic and language groups remained constant. For all three surveys, the distribution

[9] Varni, J.W., Burwinkle, T.M., Katz, E.R., Meeske, K., & Dickinson, P. (2002). The PedsQL* in pediatric cancer: Reliability and validity of the Pediatric Quality of Life Inventory* Generic Core Scales, Multidimensional Fatigue Scale, and Cancer Module. *Cancer*. 94, 2090-2106.

of returned surveys among ethnic and language groups was consistent with the ethnicity and language distribution of the total HFP population.

However, response rates within ethnic and language groups differed. Among the three surveys, Latino parents were more likely to complete the survey; African American parents were less likely to complete the survey.

With respect to the five language groups, English respondents were less likely to complete the survey, while Spanish respondents were more likely in 2001 and 2002 to complete the survey. For 2003, results revealed that Korean and Vietnamese respondents were more likely to complete the survey.

Among the age groups, parents of toddlers were more likely to return the surveys in 2001. For the 2002 and 2003 surveys, the response rates across age groups were very similar. Table 2 shows the response rates by age, language and ethnicity.

Table 2: Response rates by age, language, and ethnicity

	Baseline (2001)		Year 1 (2002)		Year 2 (2003)	
	Response Rate	Percent of Sample	Response Rate	Percent of Sample	Response Rate	Percent of Sample
AGE						
Toddler (2-4)	59%	30.5%	89%	19.5%	74%	11.1%
Young Child (5-7)	48%	24.3%	87%	26.0%	75%	24.4%
Child (8-12)	50%	31.4%	87%	35.2%	77%	39.6%
Adolescent (13-18)*	47%	13.8%	87%	19.6%	75%	24.9%
LANGUAGE†						
English	44%	43.0%	83%	38.6%	69%	36.1%
Spanish	58%	50.7%	91%	53.9%	79%	55.5%
Chinese	58%	3.3%	84%	1.43%	78%	1.5%
Korean	55%	1.7%	85%	2.31%	84%	1.9%
Vietnamese	56%	1.4%	85%	3.98%	82%	5.0%
ETHNICITY						
White	46%	13.7%	82%	12.6%	68%	11.2%
Latino	53%	61.5%	89%	62.2%	76%	62.3%
African America	37%	2.3%	79%	1.92%	66%	1.8%
Asian/Pacific Islander	54%	11.8%	82%	13.4%	79%	14.0%
Native American	46%	0.4%	89%	0.4%	83%	0.51%
Not Reported	50%	10.3%	85%	9.84%	77%	10.3%

* Because the project followed children for 2 years, and because children are no longer eligible for the program at age 19, the Baseline survey was only distributed to families with newly enrolled children who were ages 2 through 16.

† Language refers to language of the questionnaire

Health Status Scores at Baseline

The Baseline survey showed the mean parent proxy score for the HFP population surveyed was 81.38. Scores for the sub-scales ranged from

76.91 to 82.15. Given that prior research on the PedsQL™ shows that healthy children, on average, have a score of 83, the HFP results suggest that children newly enrolled in the HFP are generally healthy. Table 3 displays the Baseline scores calculated from parent responses.

Table 3: Baseline PedsQL™ Scores from Parent Reports

Scale	Score	Standard. Deviation.
Total	81.38	15.90
Physical	83.26	19.98
Psychosocial	80.25	15.82
Emotional Functioning	80.28	16.99
Social Functioning	82.15	20.08
School Functioning	76.91	20.16

A review of baseline scores by age, language and ethnicity reveals minor differences in scores in most cases. The widest range of scores appeared among age and language groups. Among the age groups, toddlers had the highest score. Among language groups, Vietnamese respondents had the highest score and Spanish respondents had the lowest scores. The scores among ethnic groups were less varied. Table 4 displays the scores among age, language and ethnic groups.

Table 4: Baseline PedsQL™ Scores from Parent Reports by Age, Language and Ethnicity

	Baseline Score	Standard Deviation
Age		
Toddler (2-4)	87.47	12.44
Young Child (5-9)	78.05	16.44
Child (8-12)	78.88	16.60
Adolescent (13-16)	79.48	16.38
Language		
Spanish	79.23	17.12
English	83.49	14.18
Chinese	83.22	13.91
Korean	82.88	15.82
Vietnamese	87.35	15.57
Ethnicity		
White	84.53	13.40
Latino	80.44	16.45
African American	82.90	13.63
Asian/Pacific Islander	82.32	15.70
Native American	83.75	15.79
Not Reported	81.17	15.77

Health Status Scores at Year 1 and Year 2

Because the overall survey population was healthy at Baseline, and remained so at Year 1 and Year 2, researchers focused the analysis of changes in health status on children who were at risk. Researchers defined "at risk" as those children who, by parent report, had scores in the lowest 25 percent of all PedsQL scores. At Baseline this comprised 2,481

children. At Year 1, 1,459 of these children remained on the program and at Year 2, there were 925 such children left in the sample. The distribution of ethnic and language groups between children with scores in the lowest quartile and children with scores in the top three quartiles were similar, with some exceptions. There was a higher percentage of Latino children (as a percentage of the total baseline population) in the lowest quartile compared to the top three quartiles. White children were more likely to be in the top three quartiles than in the lowest quartile. English respondents were less likely to be in the lowest quartile, while non-English respondents were more likely to be in the lowest quartile. Table 5 displays the ethnic and language distribution of scores between the lowest and top three quartiles.

Table 5: Ethnic and language distribution of children in the lowest and top three quartiles at Baseline

	Lowest Quartile at Baseline (total = 1,459)	Top Three Quartiles at Baseline (total = 8,782)
Ethnicity		
White	8.1%	14.2%
Latino	66.8%	61.2%
African American	1.1%	2.2%
Asian/Pacific Islander	13.2%	12.2%
Native American	0.3%	0.4%
Not Reported	10.5%	9.7%
Language		
English	29.1%	42.7%
Spanish, Vietnamese, Korean, Chinese	70.9%	57.3%

Scores for children who were in the lowest quartile at Baseline (with scores at or below 71.74) and enrolled in the program for two years showed dramatic improvement from Baseline to Year 1. The largest increase in scores was seen in the physical and social scales. There was no significant change seen from Year 1 to Year 2 as shown in Table 6, suggesting that these improvements were sustained over time. As a point of reference, a 4.5 point difference in scores is associated with a clinical change in health status that is noticeable by a parent.

It is possible that some improvement in measured health status for the lowest rank quartile would have occurred over time regardless of children's participation in Healthy Families. However, the dramatic improvement in score, of more than 12 points, is material.

Table 6: Changes in PedsQL™ Scores from Baseline to Year 1 and Year 2 in Children with Baseline Scores in the Lowest Quartile

Scores	Baseline n= 862*	Year 1	Change from Baseline to Year 1	Year 2	Change from Year 1 to Year 2	Net Change
Total	58.26	71.27	13.01	70.70	-0.57	12.44
(Std. Dev.)	(9.33)	(16.73)	-----	(17.01)	-----	----
Physical	54.51	70.84	16.33	71.15	.31	16.64
(Std. Dev.)	(17.88)	(22.71)	-----	(22.92)	-----	----
Psychosocial	60.31	71.00	10.69	70.41	-0.59	10.10
(Std. Dev.)	10.48	16.53	-----	16.46	-----	----
Emotional	66.67	72.05	5.38	71.73	-0.32	5.06
(Std.Dev.)	18.28	18.75	----	18.62	----	----
Social	57.37	71.59	14.22	72.12	0.53	14.75
(Std.Dev.)	16.82	22.58	----	21.71	----	----
School	55.65	68.45	12.80	67.05	-1.40	11.40
(Std.Dev.)	15.33	20.62	----	20.30	----	----

*Number shown reflects the number of completed parent PedsQL™ reports received
Differences in scores from Baseline to Year 1 are statistically significant.

Changes in Health Status Scores for Adolescents (ages 13 and older at baseline) in the lowest quartile

For the Year 1 report, researchers conducted an analysis to look at changes in scores among adolescents from Baseline to Year 1. The results showed that adolescents had scores that were not significantly different from all age groups. Also of note is that the changes in scores from Baseline to Year 1 for the adolescents in the lowest quartile was a dramatic improvement from Baseline and similar to that seen for all ages. Again, some improvement in health status for the lowest ranked quartile could occur over time regardless of participation in HFP. However, 12 points is a dramatic, and material improvement.

Table 7: Changes in PedsQL Total Scale scores for adolescents from Baseline to Year 1 for adolescents based on parent report

Quartiles	Baseline	Year 1	Change
Lowest Quartile - Adolescents	58.2	70.6	12.4
Lowest Quartile - All Ages	58.0	71.7	13.7
All Quartiles- Adolescents	79.7	80.9	1.2
All Quartiles - All Ages	81.3	81.3	0.0

Differences in scores within the lowest quartile are significant.

There was no significant change seen from Year 1 to Year 2 , suggesting that these improvements sustained over time. The largest increase in scores was seen in the physical and social scales.

Table 8: Changes in PedsQL Total Scale scores for adolescents in the lowest quartile from Baseline to Year 1 and Year 2 for adolescents based on parent report

Scores	Baseline n=144	Year 1	Change from Baseline to Year 1	Year 2	Change from Year 1 to Year 2	Net Change
Total	59.06	70.90	**11.84**	69.92	-0.98	10.86
(Std. Dev.)	(9.65)	(16.28)	-----	(17.03)	-----	----
Physical	58.28	71.28	**13.00**	70.87	-0.41	12.59
(Std. Dev.)	(18.78)	(21.70)	-----	(23.32)	-----	----
Psychosocial	59.44	70.51	**11.07**	69.45	-1.06	10.01
(Std. Dev.)	(10.48)	(16.53)	-----	(16.46)	-----	----
Emotional	63.43	69.92	**6.49**	69.87	-0.05	6.44
(Std.Dev.)	(20.54)	(20.33)	----	(20.60)	----	----
Social	59.45	75.25	**15.80**	73.84	-1.41	14.39
(Std.Dev.)	(16.82)	(22.58)	----	(21.71)	----	----
School	55.29	66.10	**10.81**	65.13	-0.97	9.84
(Std.Dev.)	(16.31)	(21.22)	----	(20.30)	----	----

Differences in scores from Baseline to Year 1 are significant.

Changes in Health Status Scores in Children Reported to Have a Chronic Condition

Results from the Baseline survey revealed that most children did not report a chronic condition. Children who had a reported chronic condition totaled 831, while children without a reported chronic condition totaled 8,709. The types of chronic conditions that were reported on the questionnaires included asthma, Attention Deficit Hyperactivity Disorder (ADHD) and depression. For the surveys conducted in 2002 and 2003, the proportion of children with a reported chronic medical condition remained consistent with the proportion that was seen at Baseline. Because the population surveyed was stable during the life-span of the project, changes in PedsQL scores are not attributable to shifts in the population.

In examining the differences in health status scores between those children who reported a chronic condition and those who did not, the difference in the Baseline scores was 9.14 points, which the researchers consider to be clinically significant. The subscale with the most significant difference was the school functioning subscale. Table 9 displays the Baseline scores for children with and without a reported chronic condition.

Table 9: Baseline scores for children with and without a reported chronic condition

Scale	Did not report a chronic condition	Reported a chronic condition
Total	82.32	73.18
Physical	84.08	76.99
Psychosocial Health	81.27	71.08
Emotional Functioning	81.20	71.08
Social Functioning	83.05	75.06
School Functioning	78.27	65.58

Table 10 shows the changes in the scores for children with chronic health conditions and scores in the lowest quartile at baseline. When looking at baseline scores for children in the lowest quartile with and without a reported chronic condition and changes from Year 1 to Year 2, we see that the most significant change occurred in physical and school functioning. Children without a reported condition had bigger increases in their scores although all scores for children with chronic conditions showed clinically significant improvement. Children with chronic conditions showed remarkable increases in social and school functioning from Year 1 to Year 2.

Table 10a: Changes in scores for children in the lowest quartile at baseline who had a reported chronic condition

Scale	Baseline	Year 1	Change	Year 2	Change	Net Change
Total	58.79	65.62	6.83	67.93	2.31	9.14
Physical	61.02	68.38	7.36	71.72	3.34	10.70
Psychosocial	57.63	63.75	6.12	65.83	2.08	8.20
Emotional Functioning	59.93	63.18	3.25	64.11	0.93	4.18
Social Functioning	57.63	63.75	6.12	65.83	2.08	8.20
School Functioning	53.17	63.09	9.92	62.53	-0.56	9.36

Differences in scores from Baseline to Year 1 are significant.

Table 10b: Changes in scores for children in the lowest quartile at Baseline who did not have a reported chronic condition

Scale	Baseline	Year 1	Change	Year 2	Change	Net Change
Total	58.25	72.21	13.96	71.38	-0.83	13.13
Physical	53.98	71.37	17.39	71.58	0.21	17.60
Psychosocial	60.70	72.17	11.47	71.31	-0.86	10.61
Emotional Functioning	67.61	73.52	5.91	73.04	-0.48	5.43
Social Functioning	60.70	72.17	11.47	71.31	-0.86	10.61
School Functioning	56.24	69.58	13.34	68.03	-1.55	11.79

Differences in scores from Baseline to Year 1 are significant.

Changes in School Functioning for the Sickest Children

A closer look at the individual items that constitute the school functioning subscales reveals significant improvement in PedsQL™ scores for children with scores in the lowest quartile. Table 11 shows the changes in school functioning. As seen generally in the survey results, the largest change occurred from the Baseline survey to Year 1, but these changes were sustained through Year 2. The items with the largest increase were paying attention at school and keeping up in school activities. Although the scores had an insignificant decrease from Year 1 to Year 2, the net change in scores was positive. For certain items, the increase is so great (paying attention in class, keeping up in school activities) as to show a material effect despite the likelihood that some improvement would have occurred over time regardless of participation in HFP.

Table 11: Changes in PedsQL™ School Functioning Subscale Items for children in the lowest quartile at Baseline.

Subscale Items	Baseline	Year 1	Change	Year 2	Change	Net Change
Paying attention in class	35.00	56.91	21.91	55.13	-1.78	20.13
Forgetting things	60.70	68.50	7.80	66.35	-2.15	5.65
Keeping up in school activities	36.33	59.55	23.22	59.08	-0.47	22.75
Missing school because of not feeling well	72.79	78.18	5.39	77.43	-0.75	4.64
Missing school to go to the doctor or hospital	72.46	77.73	5.27	76.35	-1.38	3.89

Differences in scores from Baseline to Year 1 are significant.

Access to Care

The modified PedsQL™ questionnaire contained three key questions related to access to care. Each parent was asked: (1) Whether their child had a personal physician in the preceding 12 months; (2) Whether their child had no problems getting the care they or their doctor felt necessary (problems getting needed care); and (3) Whether they received the care they needed (foregone health care). The rates for these items increased from Baseline to Year 1 and were sustained from Year 1 to Year 2. The largest increase seen (11.3 percentage points) was for families reporting the presence of a regular physician from Baseline to Year 1. The second largest increase was seen in families reporting no foregone care, the variable researchers believe is the best proxy for access. At Baseline, 84 percent of families reported no foregone care, but by Year 2, 92 percent reported no foregone care. There were some changes in families reporting no problems getting care. At Baseline, 80.2 percent of families reported no problems, and by Year 1 it was up to 83.7 percent.

Table 12: Access over time: The percent of sample reporting the presence of a regular physician, the absence of problems getting care, and foregoing care.

Access	Baseline	Year 1	Year 2
Regular Physician	55.7%	66.4%	66.2%
No Problems Getting Care	80.2%	83.7%	83.8%
No Foregone Health Care	84.0%	91.3%	92.4%

Differences from Baseline to Year 1 are statistically significant. Difference from Year 1 to Year 2 are not significant.

In looking at the changes in having a regular physician among ethnic and language groups, African American children (16.4 percentage points) had the largest increase followed by Latino children (12.7 percentage points). Asian/Pacific Island children showed the least change (4.6 percentage points). Spanish-language respondents showed the largest increase (12.6 percentage points) followed by English-language respondents.

Table 13: The percent of sample reporting the presence of a regular physician by ethnicity and language at Baseline, Year 1, and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	74.3%	82.6%	83.4%
Latino	49.2%	62.3%	61.6%
African American	69.8%	84.2%	86.2%
Asian/Pacific Islander	65.7%	70.0%	69.1%
Language			
English	70.0%	79.9%	78.3%
Spanish	45.2%	58.4%	57.8%
Vietnamese	37.5%	26.5%	30.3%
Korean	48.6%	53.1%	52.2%
Chinese	74.7%	74.7%	81.5%

With respect to the percent of children reporting no problems getting care, the largest increase from Baseline to Year 2 was seen in African American children. Spanish speaking families had the largest change among the five language groups.

Table 14: The percent of sample reporting no problems getting care by ethnicity and language at Baseline, Year 1 and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	87.9%	87.9%	87.7%
Latino	81.1%	84.7%	84.9%
African American	78.8%	84.5%	84.8%
Asian/Pacific Islander	75.0%	77.5%	76.6%
Language			
English	81.5%	83.9%	84.4%
Spanish	80.0%	84.7%	84.8%
Vietnamese	62.5%	62.0%	63.5%
Korean	83.9%	75.0%	80.0%
Chinese	76.8%	79.5%	75.1%

Changes in the percent of children reporting no foregone health care were more dramatic than the changes seen in no problems getting health care. African American and Asian/Pacific Islander children had an increase of over 10 percentage points. Vietnamese language respondents had an increase of 12 percentage points.

Table 15: The percent of sample reporting no foregone care by ethnicity and language at Baseline, Year 1, and Year 2

Ethnicity	Baseline	Year 1	Year 2
White	86.8%	91.5%	93.9%
Latino	84.1%	91.7%	91.9%
African American	83.3%	94.8%	93.9%
Asian/Pacific Islander	83.1%	89.1%	93.3%
Language			
English	84.4%	91.7%	93.3%
Spanish	83.5%	91.2%	91.6%
Vietnamese	80.7%	90.4%	92.6%
Korean	87.0%	92.1%	92.8%
Chinese	86.2%	89.3%	94.4%

Baseline responses received from parents of children with scores in the lowest quartile were most different for problems getting care and foregone care. Children in the lowest quartile had less improvement than children in the top three quartiles, but still significant improvement. Table 16 shows the changes in results for children that continued to be enrolled in the program for 2 years.

Table 16: Changes in presence of a personal physician, problems getting needed care and foregone health care for children with scores in the lowest and top three quartiles at Baseline who remained in the program for 2 years

	Lowest Quartile			Top Three Quartiles		
	Baseline	Year 1	Year 2	Baseline	Year 1	Year 2
Child had a personal physician						
Yes	52.4%	61.6%	60.7%	58.4%	69.0%	68.0%
Child had problems getting needed care						
Yes	29.0%	23.0%	22.0%	18.4%	15.7%	14.4%
Foregone health care						
Yes	25.0%	14.9%	12.1%	15.3%	7.5%	6.2%

Differences in scores from Baseline to Year 1 are significant.

Discussion

The results from this project strongly support the benefits the HFP provides to uninsured children. Access to care increases significantly for all children, including children who are in the most need of medical care. Reported health related quality of life and improvements in school performance for children who are in the poorest health also increase dramatically. Data show variation by race and language by parents reporting the presence of a regular physician and, to a lesser degree, by parents reporting no problems getting care. Virtually no variation occurs by race/language in reports of foregone care--the most important variable associated with access. The largest change in access and in health related quality of life occurred from the Baseline year to Year 1. Gains realized were sustained through Year 2.

There are other factors that may contribute to changes in the health related quality of life which this project could not measure. Factors such as changes in the child's environment and the quality of care provided play a role in whether (or how much) a child's quality of life improves. Aside from these factors, however, analysis conducted by the researchers suggest that access to care, specifically, reductions in foregone care, are important contributors to the improvement in health related quality of life. This is especially true for children who are in the poorest health at the time of initial enrollment in the HFP.

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This final report was prepared by Lorraine Brown, Deputy Director, with assistance from Michael Seid, Ph.D.

ATTACHMENT VII:

CALIFORNIA HEALTH INTERVIEW SURVEY

UCLA Health Policy Fact Sheet

October 2006

More than Half of California's Uninsured Children Eligible for Public Programs But Not Enrolled

Shana Alex Lavarreda, E. Richard Brown, Jean Yoon and Sungching Glenn

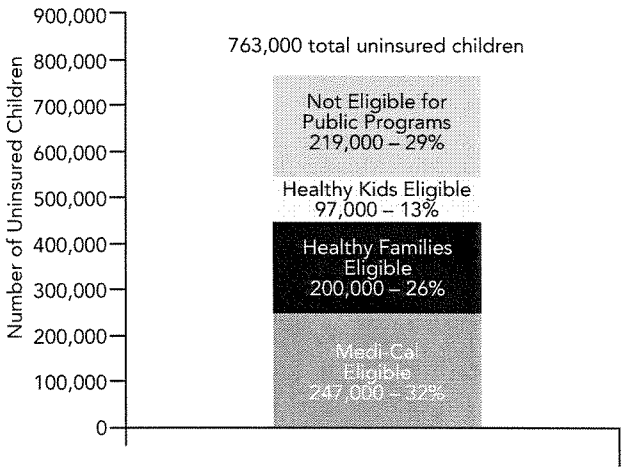
Out of the three-quarters of a million children (763,000) who were uninsured at the time of the 2005 California Health Interview Survey (CHIS 2005), nearly one-half million children (447,000) were eligible for either Medi-Cal or Healthy Families under current rules for enrollment—but they were not enrolled (Exhibit 1). The proportion of California children who were uninsured at the time of the interview fell from 10.3% in 2001 to 7.7% in 2003, but remained statistically unchanged at 7.3% in 2005. Despite increasing enrollment in Medi-Cal and Healthy Families, substantial numbers of children continue to fall through the cracks in the state's health insurance system.

Another 97,000 uninsured children were eligible for one of the 14 county-based Healthy Kids programs in 2005, but not enrolled (Exhibit 1). Many of the Healthy Kids programs have enrollment caps because they are inadequately funded by locally-raised contributions from a variety of private and public sources, effectively limiting this option even for uninsured children who meet eligibility requirements.

All together, seven in ten uninsured children were eligible for Medi-Cal, Healthy Families or the Healthy Kids programs in California in 2005. The remaining 219,000 uninsured children who were not eligible for public-program enrollment lived in counties without a Healthy Kids expansion program, or had family incomes above 300% of the federal poverty level (FPL), or both.

Even if all eligible children were enrolled in Medi-Cal and Healthy Families, an additional 316,000 children would remain uninsured. In addition, the coverage of tens of thousands of other children depends on the financially fragile Healthy Kids programs.

Exhibit 1. Eligibility for Public Programs Under Current Eligibility Rules Among Currently Uninsured Children, Ages 0-18, California, 2005



Source: 2005 California Health Interview Survey

Policy Options to Cover California's Uninsured Children

The current statewide budget includes additional funding for outreach and enrollment efforts targeted at the nearly one-half million uninsured children who are eligible for Medi-Cal or Healthy Families. Recent legislation also reduced administrative barriers to enrollment and retention in Medi-Cal and Healthy Families (SB 437, AB 1948 and AB 1851).

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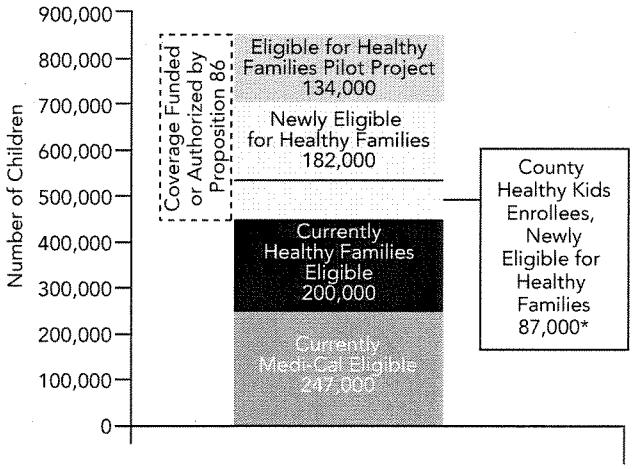
Exhibit 2. Impact of Proposition 86 on Eligibility for Public Programs Among Children, Ages 0-18, California, 2005



* This number is an administrative count of enrollees in existing Healthy Kids programs as of August 2006, not a survey estimate. Current Healthy Kids enrollees would gain stable health insurance through Proposition 86.

Source: 2005 California Health Interview Survey; data on Healthy Kids enrollees from the Institute for Health Policy Solutions "Overview of Local Children's Coverage Expansions, 8/31/06."

Proposition 86, which will be on the November 2006 election ballot, would allocate a portion of the funds raised through a tobacco tax increase to expand the Healthy Families program. If Proposition 86 is enacted, Healthy Families will be expanded to insure all children who: 1) are residents of the state; 2) are not eligible for either full-scope Medi-Cal or the existing Healthy Families program; and 3) live in households with income up to 300% FPL. Under these eligibility rules, 24% of all currently uninsured children (182,000) would be eligible for the new statewide Healthy Families expansion (Exhibit 2).

Because the newly expanded Healthy Families program would supplant the existing financially unstable Healthy Kids programs, the 87,000 Healthy Kids enrollees will also gain stable health insurance. Proposition 86 also requires the state to develop a pilot project for uninsured children who live in families with incomes above 300% FPL, most likely enabling those above Healthy Families income eligibility to buy into the program on a sliding scale of premium payments. With these programs in place, California would provide public health insurance coverage options for all children in the state who do not have access to private health insurance.

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Data Source

CHIS 2005 provides the most recent information available on health insurance coverage of Californians, both at the statewide and county levels. For more information on the California Health Interview Survey, please visit *www.chis.ucla.edu*.

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FS2006-2

UCLA Health Policy Research Brief

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One in Five Californians Were Uninsured in 2005 Despite Modest Gains in Coverage

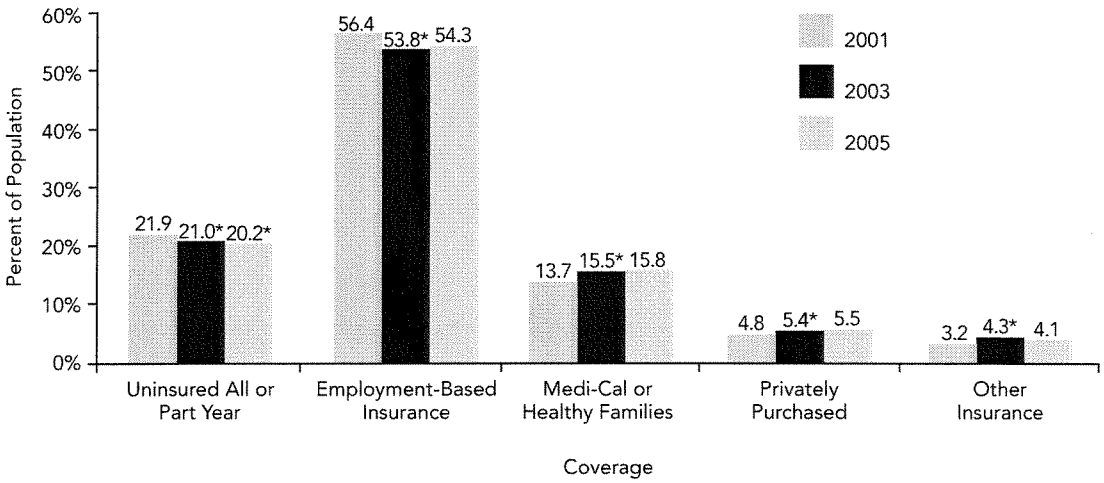
Jean Yoon, E. Richard Brown, Shana Alex Lavarreda and Sungching Glenn

Six and one-half million Californians were uninsured for all or some of 2005, a number that is as large as the combined populations of nine other states. The number of uninsured represented one in five children and nonelderly adults, a rate that was slightly lower than in 2003 due to California's tight labor markets and expanding enrollment and retention in California's public coverage programs for children. These marginal improvements are unlikely to continue unabated given the instability of employment-based insurance coverage in the face of rising costs.

In this policy brief, we compare insurance coverage over time using the California Health Interview Surveys conducted in 2001, 2003 and 2005. We look at the type of coverage over the past 12 months for both children and nonelderly adults.

Exhibit 1

Health Insurance Coverage During Last 12 Months, Ages 0-64, California, 2001 - 2005



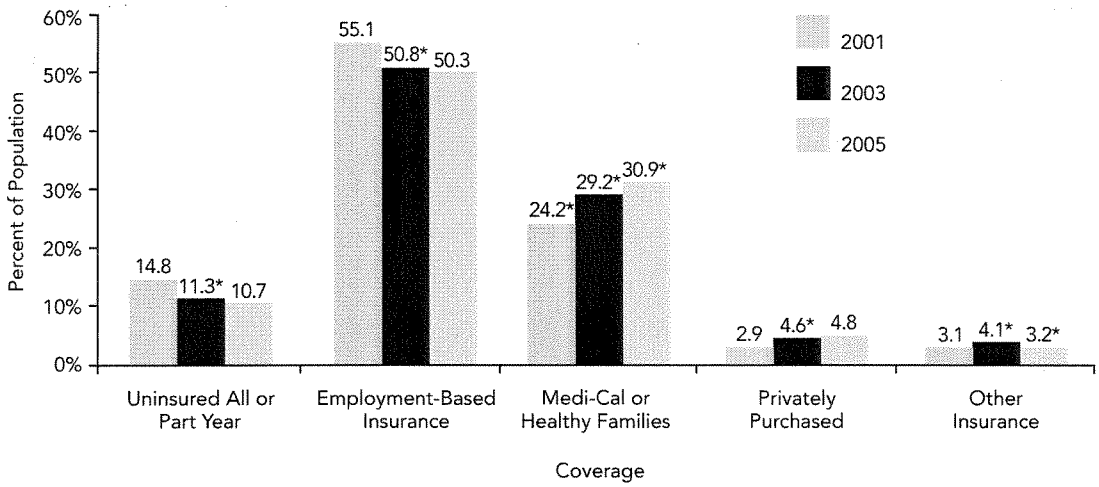
Note: Numbers and percents may not add to totals due to rounding.

Note: The category "other" includes government-sponsored programs that are not Medi-Cal or Healthy Families, as well as any combinations of insurance over the course of twelve months during which the person was never uninsured.

* Significantly different from prior year (tested at $p<0.1$).

Source: 2001, 2003 and 2005 California Health Interview Surveys

Exhibit 2 **Health Insurance Coverage During Last 12 Months, Ages 0-18, California, 2001 - 2005**



Note: Numbers and percents may not add to totals due to rounding.

Note: The category "other" includes government-sponsored programs that are not Medi-Cal or Healthy Families, as well as any combinations of insurance over the course of twelve months during which the person was never uninsured.

* Significantly different from prior year (tested at $p<0.1$).

Source: 2001, 2003 and 2005 California Health Interview Surveys

Trends in California's Health Insurance Coverage

Among all Californians under 65 years of age, the percent uninsured for all or some of the year declined from 2001 to 2003 and again in 2005 (Exhibit 1). Although there was no statistical change in coverage rates for all types of coverage between 2003 and 2005, changes since 2001 reflect fundamental weakness in employment-based insurance coverage for all Californians and the increasing importance of public program coverage for children.

In 2005 employment-based insurance covered 54.3% of the population for the entire year (a total of 17.5 million nonelderly Californians), down from 56.4% in 2001. If the rate remained the same in 2005 as it had been in 2001, an additional 645,000 Californians would have employment-based coverage.

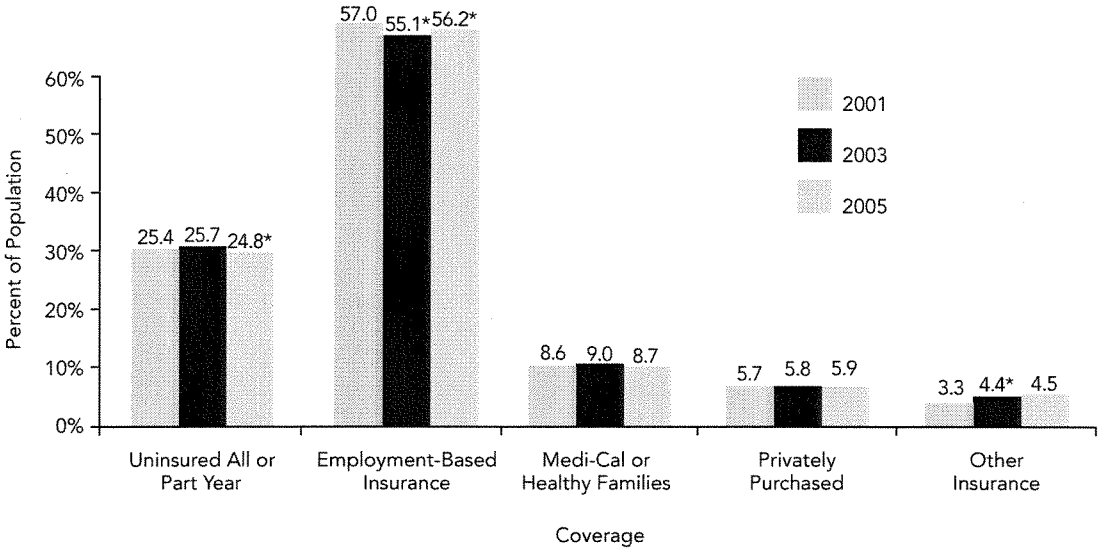
An additional 15.8% of the nonelderly population (5.1 million in all) had Medi-Cal or Healthy Families for the entire year, statistically unchanged from 2003 but higher than in 2001. Privately-purchased insurance and other public coverage each represented only a small portion of insurance coverage in California and have remained relatively stable through this period.

Trends in Children's Health Insurance Coverage

The recent expansions of children's enrollment and retention in public insurance programs led to a continuing, but not statistically significant, decline in children's uninsurance for all or part of the year—from 14.8% in 2001 to 11.3% in 2003 to 10.7% in 2005 (Exhibit 2). A total of 1.1 million children were uninsured at some time during 2005.

The percentage of children covered throughout the year by their parents' employment-based insurance fell between 2001 and 2003 but was relatively stable between 2003 and 2005, declining slightly but not significantly. A total of 5.2 million children had employment-based coverage all year in 2005. If the rate in 2005 was the same as it had been in 2001, an

Health Insurance Coverage During Last 12 Months, Ages 19-64, California, 2001 - 2005 **Exhibit 3**



Note: Numbers and percents may not add to totals due to rounding.

Note: The category "other" includes government-sponsored programs that are not Medi-Cal or Healthy Families, as well as any combinations of insurance over the course of twelve months during which the person was never uninsured.

* Significantly different from prior year (tested at $p<0.1$).

Source: 2001, 2003, and 2005 California Health Interview Surveys

additional 504,000 children would have employment-based coverage.

Medi-Cal and Healthy Families covered 3.2 million children—nearly one in three California children in 2005—up from one in four in 2001. As children's employment-based insurance declined, the all-year enrollment of otherwise uninsured children in Medi-Cal and Healthy Families rose from 24.2% in 2001 to 29.2% in 2003 and 30.9% in 2005. There has been a slight decrease in the percentage of children with other coverage from 2003 to 2005 (4.1% to 3.2%, respectively), but privately purchased health insurance was statistically unchanged.

Trends in Adults' Health Insurance Coverage

One-quarter of California adults (24.8%) experienced uninsurance during the year in 2005, a statistically significant decline since 2003, as their employment-based coverage increased slightly between 2003 and 2005 to cover 12.3 million adults (Exhibit 3). These gains, however, did not bring employment-based insurance back to its level in 2001.

The lack of public coverage options for adults is apparent in the small percentage of non-elderly adults with Medi-Cal or Healthy Families, a rate that has remained flat over time. Coverage by privately-purchased insurance and other coverage also has remained very low and flat over time. The lack of public coverage options in the face of weak employment-based coverage accounts for the greater proportion of adults who are uninsured compared to children.

Policy Implications

High employment rates and continued investment in public programs for children in California have stabilized the number of uninsured Californians since 2003. A strong economy promoted several years of job growth through 2005, and more Californians were able to afford employment-based coverage. State and local agencies, community-based organizations and foundations put money

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Web Site: www.healthpolicy.ucla.edu

and organizational resources and effort into outreach, enrollment and retention of eligible children in Medi-Cal, Healthy Families, and the local Healthy Kids programs.

But the costs of health care benefits continue to outpace inflation and wage growth, leading employers to cut back on benefits and eligibility while increasing employees' shares of cost. Variability in coverage since 2001 highlights the instability of employment-based insurance that has been the foundation of Californians' health insurance coverage. Despite efforts to provide privately purchased insurance options through tax credits and vouchers, take-up of these programs is low, and they represent only a small portion of the insured population. Thus, the long-term trend of declining employment-based insurance coverage is unlikely to be offset by growth in privately purchased coverage.

With one in five nonelderly Californians experiencing uninsurance during the year, the need for reforms of the health insurance system continues unabated.

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Data Source

Based on data from the 2001, 2003 and 2005 California Health Interview Surveys, this policy brief compares health insurance coverage during the 12 months preceding the CHIS interview for children and nonelderly adults between 2001 and 2005. CHIS 2005 provides the most recent information available on health insurance coverage of Californians, both statewide and at the county level. For more information on the California Health Interview Survey, please visit *www.chis.ucla.edu*.

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